



STATE OF TENNESSEE

DEPARTMENT OF CHILDREN'S SERVICES

# **PROVIDER POLICY MANUAL FOR RESIDENTIAL SERVICES**

JULY 1, 2003 - JUNE 30, 2004

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## **I. GENERAL REQUIREMENTS**

These requirements are applicable to all programs unless otherwise specified in this area or in the pertinent program's description area in this manual. All contracted agencies are required to make copies, train staff, and provide each facility/program with a copy of the DCS Provider Policy Manual. In the event, addendums are issued, all contracted agencies are required to disburse copies of any addendums to each facility/program **operated by them**. The Provider Policy Manual can be accessed at:

[http://www.state.tn.us/youth/children/pdf/files/provider\\_manual.pdf](http://www.state.tn.us/youth/children/pdf/files/provider_manual.pdf)

Race and/or ethnicity and/or religion shall not be the basis for a delay or denial in the placement of a child, either with regard to matching the child with a foster or adoptive family or with regard to placing a child in a group facility. Race and/or ethnicity shall otherwise be appropriate considerations in evaluating the best interest of an individual child to be matched with a particular family. DCS shall not contract and shall immediately cease contracting with any program or private agency that gives preference in its placement practices by race, ethnicity, or religion.

### **A. LICENSING VERIFICATION AND COMPLIANCE**

The Provider will furnish the Department of Children's Services **Resource Development Unit** copies of all necessary licensing to operate before becoming eligible to accept children. Adherence to all licensing standards and DCS Provider Policy Manual will be maintained. DCS shall not contract with any agency which has an owner, member of its Board of Directors or member of its Board of Trustees who holds any other positions which may influence the placements provided to foster children.

### **B. DCS ADMINISTRATIVE REVIEWS**

The Department of Children's Services monitors contract agency providers in several ways. They receive external monitoring from the Department of Finance and Administration, Program Accountability Review (PAR). **PAR** reports are received in the Quality Assurance Division, Residential Continuum Monitoring Unit. That Unit will request that the provider complete and return a corrective action plan when there are outstanding non-compliance issues. The QA Division also reviews and tracks incident reports, and follows up on complaints. The QA Division will follow up on outstanding non-compliance issues, and conduct reviews as needed to ensure that youth in the contract agency setting are receiving needed services.

When the QA Division, or any Regional Administrator, Assistant Commissioner, or the Resource Development Division has a concern about a contract agency, they may request that the Network Performance Review Committee be convened to discuss and determine appropriate action to be taken regarding an agency. The Network Performance Review Committee consists of the QA Division, the Resource Development Division, and the

applicable Regional Administrator and Assistant Commissioner. Issues will be reviewed, and the committee might recommend that a further site review of the agency is needed, or that administrative action should be taken. For instance, the committee could recommend that due to significant non-compliance or safety concerns, admissions to the facility should be limited in number, or admissions should be suspended. This kind of contract limitation is administered when it is determined that the agency needs to resolve internal compliance issues before it can effectively add additional youth to the program.

In making its determination, the committee reviews outstanding corrective action plans, current compliance or non-compliance, incident reports, CPS investigations, and any other pertinent information. If the committee recommends an administrative action such as a contract limitation, the QA Division will make the recommendation to the Commissioner of the Department. Upon approval of any recommendations, the provider will be informed of any actions, and will be notified regarding what corrective action is required by the provider in order for the administrative action to be lifted. Administrative action may include cancellation of contract and removal of youth if necessary for safety reasons. Generally, follow up review by the Department will be conducted before such actions are lifted.

### **C. COMPLIANCE WITH REQUESTS FOR DATA**

The Provider will comply with any requests made by the Department of Children's Services, the State, or agencies authorized by the State for data, and will adhere to all inquiries for information within the time frames specified. **Data to be submitted by Provider Agencies:**

<b>Name of Report</b>	<b>Type Contracts to Report</b>	<b>Frequency of Reports</b>	<b>Responsible Departmental Staff</b>	<b>Purpose of Report</b>
Special Needs Adoption Report	Agencies with Special Needs Adoption Contract	Monthly by the 5 <sup>th</sup> of the month	Anne Pruett, Planning, Research and Policy	Outcome Monitoring and Reports
Annual Licensing Report	All Agencies Licensed by Department of Children's Services	Annual	Jerry Hughett, Licensing Division	Legislative Mandate
Monthly Performance Report	All Residential Contract Agencies	10 <sup>th</sup> of Every Month	Karen Davenport Quality Assurance Division	Brian A. compliance and monitoring, Contract Review

Foster Home Application Tracking Report and Foster Home Report	All agencies with foster and adoptive homes serving custody youth	Monthly by the 10 <sup>th</sup> of every month	Madge Green, Quality Assurance Division	Brian A. requirement
Incident Reports	All DCS and all contract agencies	As episodes occur	Les Sawyers, Quality Assurance Division	Incident monitoring
Progress Reports for Youth	All agencies serving custody youth	Quarterly or as needed	Home County Case Manager	Track progress of youth and family
Time and Cost Study	All contract agencies	Every three years	Doug Swisher, Fiscal Division	Determine allocation of funding mix and assist with rate
Education Release Form	All agencies with youth in placement	Last day of the month	DOE and copy to educational division	Required by interagency agreement and to provide liason
Special Education Census Form	Agencies with DOE approved schools	As necessary	Education Division	Special Ed funding
Subcontracts	Any agency with a subcontract	Prior to subcontract	Quality Assurance	Contract Requirement
Exception Form	All agencies with DCS youth in placement	Prior to exception placement	Regional Administrator in each region	Brian A. requirement

**The Department of Children's Services shall have full access to all information and files relating to staff, volunteers, fiscal accountability, and clients in all programs.**

#### **D. COMPLIANCE WITH TENNCARE**

Providers shall comply with the TennCare managed health care system that has been implemented by the State of Tennessee. Department of Children's Services requires Providers to maintain medical records for five years (*Rules for Medicaid 1200-13-1-05*) (*Rules for Bureau of TennCare Rule 1200-13-12-08*) and to disclose ownership and control information on a Provider's owners and any other persons convicted of criminal offenses against Medicare or Medicaid (42 CFR 44 subpart B).

The contract agency must not encourage nor in any way suggest to parents/guardians of a non-custodial child that the child should be put in custody in order to receive services. If the agency is approached by the parent/guardian, and the agency **serves only DCS custody children**, the contract agency Provider should refer the parent/guardian to the BHO or to the DCS Regional Health Unit. The contract agency Provider must not suggest custody by indicating the agency only serves custody children and **must not provide** the parent/guardian with additional information.

### **1. What is TennCare?**

The State of Tennessee contracts with Managed Care Organizations (MCOs) and a Behavioral Health Organization (BHO) to deliver health services to enrollees. The state pays a capitation fee for each enrollee in TennCare. The health organizations then contract with health care providers. Each health organization must have a sufficient network of health care providers, and the contract with the state outlines certain network requirements.

Effective 7/1/01, TennCare has contracted with BlueCross/BlueShield to serve as the MCO for children in custody. This MCO is TennCare Select. TennCare is notified when children come into custody and they are assigned TennCare Select. **While TennCare Select will continue to be the MCO for children in custody, beginning June 1, 2003, all EPSDT screenings for TennCare enrolled custody children will be completed at the local health department. This does not include dental screenings.**

### **2. Eligibility for TennCare**

When children are admitted to custody, they are immediately eligible for TennCare for a period of 45 days. During that 45 day period an application for TennCare is fully completed and eligibility is determined. The DCS case manager provides information to the child welfare benefits case manager. The majority of children will be eligible through the traditional Medicaid (Child in Special Living Arrangements/SSI). As of 07/01/02, if the child is not eligible through this traditional financial eligibility, DCS eligibility workers will determine if the child is eligible through TennCare Standard. Previously, if a child was not eligible for traditional Medicaid, the case was referred to the local Department of Health for TennCare application as an uninsured (what some DCS employees call "Pure" TennCare). The Department of Health will no longer be processing TennCare applications as of 07/01/02.

### **3. What Is Covered Under TennCare?**

Covered under TennCare are: **all medically necessary** services, through the assigned TennCare Select, and behavioral services, through the BHO (and through DCS, when DCS administers behavioral benefits through contracted 24-hour residential care facilities.) **As of 3/28/03 TennCare has announced they will not implement the planned differences between TennCare Medicaid and TennCare Standard. This means that all TennCare members under the age of 21 will continue to have EPSDT rights. EPSDT requires TennCare to provide all medically needed services to treat, cure, or prevent a condition from worsening. If you experience difficulty in**

**accessing any medical or behavioral health service for a child in custody, contact the child's home county Health unit TennCare representative for assistance.**

**a. Medical services**

Children in state custody on TennCare are able to receive medical services through their assigned TennCare Select. These services are detailed in the document entitled TennCare Covered Services, which may be found in Appendix B of this manual. Medical services include hospital, preventive health screenings (EPSDT), dental and vision services. Each child is assigned to a primary care physician (PCP). That PCP orders the necessary services. Some services require prior authorization, and the PCP usually facilitates this. Children in custody are assigned to a PCP in the Best Practice Network (BPN). For PCP assignment or change, contact the case manager or the Regional TennCare Representative.

**b. Behavioral services**

Children in state custody are able to receive behavioral health services covered by TennCare through their BHO and through DCS. **DCS Contract Providers must take care that services provided through the BHO are not services that should be provided under their contract to serve the child. When a provider is contracted to provide behavioral health services to a TennCare eligible child, DCS uses TennCare funds to pay the Provider for these services.** Behavioral health services, like medical health services, also fall under the federal law that mandates all children under the age of 21 who are receiving Medicaid (TennCare) have provided for **each child** treatment to cure, or prevent a condition from worsening. Behavioral therapy services or basic health outpatient mental health services are included in the rate for level 3 and above.

**(1) Basic benefits**

Service type:

- Psychiatric inpatient facility services
- Outpatient mental health services
  - M.D. services
  - Non-M.D. services
  - Day treatment
- Pharmacy services for psychotropic medication
- Lab services related to psychiatric needs
- Transportation to covered mental health services
- Inpatient substance abuse treatment and detoxification
- Outpatient substance abuse treatment and detoxification
- Specialized crisis services
  - Mobile crisis services
  - Specialized crisis respite

**The BHO is required to give an appointment for outpatient services within 14 days; if appointment date exceeds this time, it is a delay in service. In this sort of situation, i.e., you are trying to get an appointment within the guaranteed 14-day period but are unsuccessful and therefore you are**

**immediately aware of the delay, contact the TennCare Rep. directly to have the Rep. file an appeal.**

In addition, the BHO is required to provide services based on the individual needs of patients. If you suspect that prescriptions for treatment are being given dependent on the availability of resources, please contact the TennCare Rep to file an appeal.

Located in Appendix B, Part 1, is a document specifying the step-by-step procedure for obtaining a psychological evaluation covered by TennCare.

## **(2) Behavioral services administered by DCS**

In addition, children are eligible for behavioral services administered by DCS when the child is in state custody. DCS contracts with Providers to render 24-hour residential services to children in its custody. These services, known as continuum services or as Level I / II / III / IV, include counseling, behavioral treatment, and A & D. DCS Resource Management manages these resources. Children receiving the benefit of residential treatment by a contracted DCS Provider continue to be eligible for the Benefit package provided by the BHO, but Providers must take care that services provided through the BHO are not services that should be provided under their contract to serve the child. When a Provider is contracted to provide behavioral health to a TennCare eligible child, DCS uses TennCare funds to pay the Provider for these services. It should also be noted that children in 24-hour residential care obtain their medical services through the MCO.

### **(a) Due process requirements**

Because DCS is providing TennCare services to children in state custody administer behavioral benefits through its contracted Providers, DCS must also provide an opportunity for those TennCare enrollees in its custody to have written notice of denied services and an opportunity to appeal those denied services (in the same way this is required by the BHO or MCO). The process that DCS has agreed to in order to ensure that our children's rights are protected is outlined in Appendix B. This information concerns the expanded and revised Process For TennCare Appeals On DCS Administered TennCare Services, including the Notice of Action and the TennCare Medical Care Appeal Form, may be found in Appendix B of the Provider Policy Manual. Also in Appendix B is the particular notice that Continuum Providers must send on a monthly basis (with child's monthly treatment summary and any Type A incident reports attached) along with the TennCare Medical Care Appeal Form. NOTE: All procedures required at each staffing of a child must be carried out in compliance with the revised DCS Appeals Process.

### **(b) TennCare appeal process**

The TennCare Medical Care Appeal Form (located in Appendix B, Part 2) is the form used to file an appeal regarding MCO, BHO, and also

DCS-administered behavioral health services. Whenever a TennCare service is delayed, denied, reduced, suspended or terminated DCS must assure that an appeal is filed. The above cited appeal language (denied, reduced, suspended, delayed or terminated) should be interpreted broadly. If you are experiencing difficulty in accessing a needed service, please call the child's home county health unit for assistance! See Appendix B for additional information.

#### **4. Mental Health Case Management Referrals**

Mental health case management is a TennCare provided service to assist TennCare recipients in "managing" their mental health needs. This service assists children or adults in accessing needed mental health services, medication management, and coordination of care. In order to facilitate continuity of care for children stepping down from non-continuum residential services, the following procedures requesting mental health case management should be followed:

##### **a. Levels I and II**

If a foster parent feels the child needs mental health case management, the foster parent and/or the home county case manager should call the local community mental health center and request the child receive mental health case management services. If the foster parent or case manager experiences any difficulty they should contact the DCS health unit for assistance.

##### **b. Level III**

Fourteen days prior to a discharge staffing, the mental health case management memo shall be sent to the home county case manager. The case manager will be facilitating a referral for mental health case management to assist DCS in assuring that the child's mental health treatment needs are met in the community. This referral process, as explained in the memo, will include a release of information form. Please assist the home county case manager and the mental health case manager in accessing the needed information so that the participation in the discharge staffing is meaningful.

##### **c. Level IV**

The Discharge Staffing Notification, the Grier notice and the Release of Information will be faxed to the mental health provider, if a relationship already exists. If not, the forms will be faxed to AdvoCare at 615-313-4481 and a referral will be sent to the mental health provider in the area. These forms will be completed and faxed a minimum of 10 days and a maximum of 30 days prior to the scheduled discharge. This will serve as a notice to the provider that the child is scheduled for discharge and that mental health case management is being recommended.

#### **5. EPSDT Services (Early Periodic Screening Diagnosis and Treatment)**

All children in DCS custody must receive an EPSDT within 30 days of coming into DCS custody and in accordance with the AAP Periodicity Schedule thereafter.

Beginning June 1, 2003, all EPSDT screenings for TennCare enrolled children will be performed at the regional health department. The health department will provide an

EPSDT screening appointment with twenty-one (21) days of request. Please note that per policy 20.7 children in a YDC must receive their EPSDT within seven (7) days of coming into custody.

The AAP Periodicity Schedule:

At birth	4 months	15 months
2-4 days	6 months	18 months
1 month	9 months	24 months
2 months	12 months	Yearly from 3-20

Per policy 20.7 the following information shall accompany the child to the EPSDT whenever it is available:

- Private Insurance information, TennCare card, and/or TennCare immediate eligibility letter
- Home county case manager's name and fax number
- Name and address of Primary Care Physician
- Immunization record
- Explanation of any known or suspected medical problem to be addressed
- Release of information and custody order
- Initial health questionnaire
- TNKids Medical Summary
- Social history
- Past medical records, and
- Short Form Assessment for children under five (5)
- PEDS Response Form (Birth – 9 years of age) or
- Periodic System Checklist (PSC) (6 years of age to 16 years of age)

If an item listed above is not provided, the case manager or the foster parent shall explain why the document is not available to the practitioner conducting the initial or annual screening.

The child's EPSDT must contain all seven (7) components of an EPSDT screening. The seven components of an EPSDT screening are:

- Comprehensive health (physical and behavioral) and development history
- Comprehensive examination
- Appropriate immunization according to age and health history
- Appropriate laboratory tests according to age and health history
- Health education
- Hearing screen, and
- Vision screen

The Home county case manager, foster parent, or contract facility case manager must accompany the child to the EPSDT examination. No youth will be left at the regional health department without one of the above adults.

The contract facility is responsible for ensuring that the home county case manager's name and fax number is given to the health department along with the other information listed above. Within two (2) working days after the EPSDT screening, the health department practitioner shall fax to the DCS case manager and the primary care physician a letter confirming whether all seven components of the screening were completed and stating any concerns that should be referred to the primary care physician.

The home county case manager must enter the date of the EPSDT screening and the status of the EPSDT seven components into TNKids within three (3) calendar days from the date the letter was received or the first actual working day after the letter was received.

When the EPSDT confirmation letter indicates:

- a. The primary care provider should see the child for follow-up, or
- b. That all seven components of the screen were not complete

The regional health advocacy unit nurse shall receive a copy of the letter from the home county case manager.

The regional health advocacy nurse will track children requiring follow-up care to ensure that case managers appropriately follow-up with the primary care physician.

The person taking the child to the screening should request from the provider written documentation that the screening was complete and what further care the child needs.

Per policy 20A.7, the case manager, biological parent, or foster parent may sign routine consent forms.

## **6. DCS Regional Health Units**

DCS has now established regional Health Units to improve the medical and behavioral services for the children served by DCS. These Health Units consist of a regional TennCare representative, a nurse or nurse practitioner, and a psychologist. The Health Units will be responsible for providing programmatic supports and facilitating/coordinating covered services through the MCOs and BHO. Names of the TennCare representatives and the other members of each regional Health Unit may be found in Appendix B, **Part 1**, of the Provider Policy Manual. While the Health Units may provide programmatic support to case managers regarding appropriate determination of needed benefits administered by DCS, they are not intended to supplant or supervise Resource Management and its role in coordinating residential placements by contracted Providers. Resource Management will continue to play the primary role in placements with contracted DCS Providers, and therefore is the appropriate contact regarding issues for the DCS Appeals process.

## **7. Material in Appendix B**

In Appendix B, Part 1, you will find the most updated listing of the individuals in the DCS Regional Health Units, basic health care advocacy information, various health care and medication consent forms, and EPSDT information.

Appendix B, Part 1, contains information on Youth Villages crisis services which will replace the community mental health mobile crisis services on June 1, 2003.

Appendix B, Part 2, contains the TennCare Medical Care Appeal Form, which in addition to its usage as the means to appeal the DCS administered TennCare behavioral benefits, is the form used to appeal MCO/BHO services. **It** should be used to make a formal complaint about specific health care concerns, such as an individual's TennCare plan (MCO/BHO) not okaying care, or medicine a doctor has ordered for a child. **Additionally, it should be used** when the TennCare plan wants to stop or reduce health care, or to appeal/make complaint about any other aspect of the child's health care services. **Also, in Appendix B, Part 2, you will find flow charts indicating the process for both TennCare appeals and DCS (behavioral health services) appeals.**

## **E. PLANNING FOR CHILDREN**

All children/youth placed in the custody of the Department of Children's Services shall have a written permanency plan. The permanency plan shall establish realistic goals for the family, the child/youth, and the Department necessary to achieve permanency for the child/youth. The permanency plan shall identify the permanency goal or concurrent permanency goals for the child/youth. The issues that are a barrier to safety and permanency will be clearly identified and the steps necessary to remove the barriers, building on the child and family strengths and other available resources, will be outlined for each party to the plan. The court of venue shall ratify or approve the permanency plan with the exception of youth placed in the Youth Development Centers.

Fundamental to the appropriate development of a permanency plan is that no plan shall be developed outside the context of a permanency plan child and family team meeting. Plans developed should reflect issues identified in the context of the child and family team meeting and to the extent possible should reflect the consensus of the permanency plan child and family team meeting participants while still meeting the Department's responsibility to assure child safety, permanency, and well being.

The permanency plan is only required for children/youth under 18 years old if adjudicated dependent/neglected or unruly, or under 19 years old if adjudicated delinquent. A permanency plan is not required for youth age 18 and older who are receiving voluntary services.

### **1. Procedures**

#### **a. Development of a Permanency Plan**

- (1)** Foster care is the temporary placement of a child/youth in the custody of the Department of Children's Services for care outside the home of a parent or other legal custodian. Such a placement may be the result of a court order, a voluntary placement agreement, or the surrender of parental rights. A permanency plan, which is to be developed in the context of a child and family team meeting, helps to ensure that the child/youth's needs are met

while s/he is temporarily in the custody of the Department of Children's Services and that s/he is safely and permanently placed in the care of a family in a timely manner.

- (2) Prior to a permanency plan child and family team meeting, the Department's uniform assessment protocol shall be completed. The results of the assessment shall be used to assist in determining appropriate intervention for the child/youth and the family. All assessment instruments and reports utilized in the permanency plan child and family team meeting will be documented either by retaining a copy of the instrument or report in the hard copy file, or when appropriate, entering the information in TN KIDS.
- (3) A permanency plan child and family team meeting shall be held within fifteen (15) working days of a child/youth's placement in custody.
  - (a) Every effort will be made to schedule the child and family team meeting by talking with all parties and agreeing on a time for the meeting as quickly as possible. Staff should consider scheduling a permanency plan child and family team meeting at the conclusion of the first court hearing. See DCS Policy 31.8, *Initial Child and Family Team Meeting*.
  - (b) If not scheduled by agreement, notice to the parties to the case and to the foster parents must be given at least seven (7) days in advance of the child and family team meeting if notice is by telephone, and at least ten (10) days in advance if notice is by certified mail.
  - (c) The permanency plan child and family team meeting must be held within fifteen (15) working days even if all persons cannot be present. Letters and telephone participation should be encouraged for those parties not in attendance.
  - (d) The child/youth's case manager, supervisor, Assessment Unit Case Manager, or other trained facilitator shall facilitate the permanency plan child and family team meeting.
  - (e) Regardless of who facilitates any child and family team meeting, the child/youth's case manager must be in attendance.
  - (f) The permanency plan child and family team meeting shall also involve:
    - Parents or former legal custodian
    - Child/youth (mandatory if child/youth is 12 years of age or older, and as appropriate for younger children)
    - Extended family members
    - Support persons as defined by the family
    - Therapist
    - CASA volunteer
    - Foster Parents
    - Contract agency staff persons
    - Specialized DCS staff persons, as needed, such as Educational Specialists, Health Unit Members, Juvenile Justice Staff, and Permanency Support Unit Staff
    - Guardian Ad Litem

- Interpreter, as needed
  - Attorney for the child/youth's parents
  - DCS attorney
  - CPS case manager (if first meeting since investigation and case has been transferred to the Foster Care Unit).
- (g) The permanency plan child and family team meeting shall be conducted in accordance with DCS Policy *31.7 Engaging Families*. The permanency plan must be developed with the participants at the time of the child and family team meeting. Plans may be handwritten.
- (h) At the conclusion of the permanency plan child and family team meeting:
- The case manager is responsible for seeing that all the necessary signatures are obtained, including that of the parents, the case manager, and the team leader.
  - A copy of the permanency plan (even if hand written) shall be provided to the child/youth (if age appropriate), parents or other former legal custodian, and the primary care taker (i.e., foster parents) at the conclusion of the child and family team meeting. If the child/youth is in a contract residential program, a copy of the permanency plan shall be provided to the contract agency. If any changes are made to the permanency plan after signing by the parties, new signatures recognizing the changes must be obtained.
  - If significant individuals (Guardian ad Litem, foster parents, etc.) are unable to attend the child and family team meeting, those individuals should be encouraged to participate and give input via telephone or correspondence. It is the case manager's responsibility to ensure that all parties to the case who were not in attendance are provided with a copy of the plan and are advised of the outcome of the child and family team meeting.
- (4) Unless a parent's rights have been terminated or surrendered, the Department must involve all known parents in the permanency planning process. This includes biological parents, legal parents and alleged fathers.
- (a) Parents must be given adequate notice of all child and family team meetings resulting in the development of the permanency plan. Parents may have their attorney present at these child and family team meetings.
- (b) The permanency plan shall include all necessary actions to be completed by parents and services provided to parents to facilitate the child/youth achieving his or her permanency goal.
- (c) As it is the Department's policy to also involve children/youth in their permanency planning (it is required for children/youth age 12 and older), considerations may be given to safety and emotional issues as they pertain to having parents and children/youth together at the permanency plan child and family team meeting. Staff shall assess this issue on a case-by-case basis and provide alternative means of participation if the child/youth's best interest warrants their exclusion.

If at all possible, it is preferred that all parties, parents and children attend the child and family team meeting jointly.

- (d) Unless it is contrary to the child/youth's best interest, incarcerated parents must be included in the development of the permanency plan for a child/youth in DCS custody. Incarcerated parents must be encouraged to participate in the plan and meet their parental responsibilities by corresponding with the Department and the child/youth, contributing to the child/youth's support, and helping to formulate a realistic plan for the child/youth's care. Staff should assess the feasibility and desirability of the incarcerated parent's participation in the permanency plan.

(5) The permanency goals to be considered for a child/youth are as follows:

**(a) Return to Parent**

- The goal of return to parent is to be utilized when the parent(s) is/are working to remedy the problem(s) that led to the removal of the child/youth. This is the preferred goal if the conditions that led to the removal can be remedied and it is safe for the child/youth to return to the home. In the case of a child/youth removed from, and returning to, a non-parent caregiver, the Department shall encourage and assist the caregiver to obtain temporary legal custody of the child/youth.
- If a child/youth has been in the custody of the Department for 12 months or more, the goal of return to parent may not be used unless the DCS supervisor gives written approval, there is written justification of continuing this goal in the record, and the additional services necessary or circumstances which must occur to accomplish the goal are identified.
- When a child/youth has been in the custody of the Department for 15 months or more of the past 22 months, a goal of return to parent may not be used unless there are compelling circumstances and reasons to believe the child can be returned home within a specific and reasonable time period. The compelling circumstances and DCS supervisory approval must be documented in the record.

**(b) Exit Custody to Live with Relative**

- If a child/youth is unable to return to the parent(s) or caregiver(s) from whom the child/youth was removed, and the plan is that the child/youth will find permanence outside the foster care system through a legal relationship (other than adoption) with a relative, the appropriate goal is "*Exit Custody to Live With Relative.*" This goal is appropriate for children/youth with the plan for a relative to assume custody of the child/youth. The goal may be appropriate whether or not the current placement is with a relative.
- Searches for relatives should begin at the initiation of a CPS investigation or Court involvement. If a child/youth is placed with a relative and the relative requires continued support from the Department in the form of the foster care board rate and/or foster care case management necessitating that the child/youth remain in

the custody of the Department, the goal of “*Planned Permanent Living Arrangement*” should be utilized (see section A.4.d. of this policy). The goal of “*Exit Custody to Live With Relative*” is only appropriate in cases where the child/youth will be exiting the custody of the Department to find permanency in the custody of a relative without the benefit of adoption by the relative.

**(c) Adoption**

Upon identifying that a child/youth in DCS custody is unlikely to be able to return to the parent(s)/ caretaker(s) and that there are no willing and appropriate relatives for the purpose of the child/youth exiting custody to live with relatives, and if the Department appears to have grounds for termination of parental rights; or upon a request by the parent(s) to voluntarily surrender their parental rights, a permanency goal of adoption may be established for a child/youth. The above does not preclude the possibility of relative adoption by either parties serving as relative placements or by other relatives. The case manager must consider the following when establishing adoption as a child/youth’s sole permanency goal:

- Reasonable casework services have been offered to facilitate return to the parent with little or no progress toward removal or reduction of risks to the child/youth. In other words, there is substantial non-compliance or lack of progress with the permanency plan such that the risks have not been adequately mitigated or eliminated.
- The parents are unlikely to remedy the conditions presenting barriers to the child/youth returning home in the near future.
- No relatives have been found who are available, willing, and appropriate as permanent placements either within the foster care system (PPLA with relative) or outside the foster care system (Exit Custody to Live with Relative).
- An advisory body (i.e. Foster Care Review Board, Multi-Disciplinary Child/Youth Abuse Review Team) has recommended alternative goal planning.
- If the child/youth is 13 years old or older, his/her views regarding adoption have been explored in a counseling setting.
- Adoption is considered to be in the child/youth’s best interest.
- Conditions exist providing the legal basis for termination of parental rights. With the passage of the Adoption and Safe Families Act of 1997 (ASFA), the Department, unless certain criteria outlined in ASFA exists and are documented in the record, must file a petition for termination of parental rights for children/youth who have been in care for 15 of the last 22 months. A petition may be filed immediately, and reasonable efforts are unnecessary, if certain criteria outlined in ASFA are met. To explore ASFA criteria in relation to termination of parental rights and establishing a goal of adoption, the case manager shall consult with the DCS attorney.

- Upon identifying a sole permanency goal of adoption, efforts must begin to free the child/youth for adoptive placement and to recruit and locate an appropriate adoptive family. This effort must occur without delay, even if the goal is changed to adoption prior to the filing of the petition to terminate parental rights.

**(d) Planned Permanent Living Arrangement (PPLA)**

- (1) It is the Department's goal for all children/youth to grow up in a nurturing, caring family. Permanency may be achieved by children/youth exiting care to the custody of birth parent(s), adoptive parents, or relatives. When it is not possible for children/youth to exit care to permanency as just described, a goal of Planned Permanent Living Arrangement (PPLA) – With Relatives (relation may be by blood or marriage, and may include persons previously related by a marriage that is now dissolved, such as an ex-step-parent) or With Non-Relatives may be established.
- (2) Prior to a child and family team meeting to address possibly changing the child/youth's permanency goal to PPLA, or if this goal is arrived at during a meeting unexpectedly, the case must be referred to the Permanency Support Unit supervisor for review and possible assignment to the Permanency Support Unit.
- (3) Staff shall not take a permanency plan with a new sole goal of PPLA (nor a recommendation to change to a sole goal of PPLA) to the Foster Care Review Board or to Court until it has been referred to and reviewed by the Permanency Support Unit.
- (4) If the Permanency Support Unit and assigned case management staff cannot reach a consensus opinion regarding changing to a sole goal of PPLA, the case will be forwarded to the Regional Administrator for a decision. If the goal is to be changed to a sole goal of PPLA, it is then reflected in a revised permanency plan.
- (5) To achieve permanence, foster parents to a child/youth with a permanency goal of PPLA will be encouraged to sign form CS-0592, *Long Term Placement Agreement* or in the case of a child/youth placed through a contract a long term agreement of the contract agency's developing. The family committing to the child/youth should be documented by name on the permanency plan. They will be asked to serve as a family resource for the child/youth throughout his/her adulthood, treating the future adult as a member of the family providing all emotional and familial support. If, at the time of identifying PPLA as a goal, a child/youth's family is not able to make a commitment through a Long Term Placement Agreement, another family will be sought to provide the above commitment and possibly placement. If the child/youth is placed with a contract agency foster family, it is the responsibility of the contract agency case manager to approach potential families to commit to a Long Term Placement Agreement. DCS staff may provide explanation to the contract agency foster family, but should not directly approach the family about this commitment.

- (6) In the limited incidents when a child/youth is in a facility group placement (not placed with a family), and PPLA is being considered as the sole permanency goal, extreme efforts must be made and documented in the permanency plan regarding the Department's recruiting and retaining a family resource for visitation support into and through the child/youth's adulthood. The family resource may be related or unrelated to the child/youth, and in special circumstances, may be the birth parent(s). The family is encouraged to consider serving the child/youth as a foster family if appropriate and/or support the child in transitioning to another foster home. Similar to above, the family committing to the child/youth should be documented in the permanency plan and should be involved in the development of permanency plans for the child/youth. Families making a commitment to children needing residential treatment, and for whom PPLA is an appropriate goal, will be asked to sign form CS-0613, *Statement of Family Commitment*. Contract Providers should facilitate and coordinate this process for youth in their care.
- (7) PPLA may be appropriate in, but is not limited to, the following circumstances:
- The child/youth is older (generally 15 years of age and above if placed with a non-relative).
  - After adoption preparation services are provided, the child/youth refuses to be placed for adoption (specifically if 14 years of age and above). Adoption preparation can be provided by the adoption team or by a therapist.
  - The child/youth has significant and beneficial bonds with his/her birth parent(s), but is unable to return to them.
  - The child/youth is approaching the age of majority, and desires to make a transition into independent living with the ongoing support of foster parents.
  - The child/youth's foster care placement is with a relative and due to family circumstances, adoption is not in the child/youth's and/or relative's best interest. However, continuation in foster care is necessary to support the placement.
  - The youth is adjudicated delinquent, has a determinate sentence, and will be in the custody of the Department until s/he reaches adulthood. (If the youth remains in a group placement throughout his/her sentence, the Department shall seek a family resource commitment. This resource may be a parent, relative, or non-relative.)
- (8) There are specific considerations given to the child/youth's age in determining the appropriateness of PPLA as a goal. In the case of PPLA –with Non-Relative a youth must be 15 years of age or older. There is no minimum age for a child/youth to be considered for a goal of PPLA – With Relative. However, there must be adequate documentation in the child/youth's record as to the compelling reason why return of child/youth to parent, adoption and exit custody

to live with relative would not be in the best interest of the child/youth, because of the child/youth's special needs or circumstances.

(e) The use of two permanency goals may be appropriate. The use of concurrent goals is described in DCS policy 16.41, *Concurrent Planning*.

**(f) Reasonable Efforts Not Required**

- While return to parent is typically the permanency goal of choice, respecting the parents' rights as well as the parent/child connections and bond, under certain defined circumstances, reasonable efforts to reunify the child/youth with his/her parent(s) or former legal custodian are not required by DCS and the establishment of a goal is impacted by that decision. The DCS lawyer should be immediately consulted if the case manager is considering that reasonable efforts may not be required.
- For instance, reasonable efforts are not required when a Court of competent jurisdiction has found that certain defined felonies have been committed against the child/youth or another child/youth of the parents. TCA 37-1-166 (a) (4) lists those felonies: murder of any sibling or half-sibling of the child/youth or other children residing in the home; voluntary manslaughter of any sibling or half-sibling or other children/youth in the home; aided or abetted to commit murder or manslaughter on the child/youth, sibling or other child/youth in home; felony assault that resulted in serious bodily injury to the child/youth, sibling, half-sibling or other child/youth in home.
- Reasonable efforts are also not required if the parental rights of the parent to a sibling or half-sibling have been involuntarily terminated.
- Reasonable efforts do not have to be made if the parent has subjected the child/youth who is the subject of the petition or any sibling, half-sibling or other child/youth residing in the home to aggravated circumstances defined in TCA 36-1-102(9)---(abandonment, abandonment of an infant, aggravated assault, aggravated kidnapping, especially aggravated kidnapping, aggravated child/youth abuse and neglect, aggravated sexual exploitation of a minor, especially aggravated sexual exploitation of a minor, aggravated rape, rape, rape of a child/youth, incest, or severe child abuse. If there has been an abandonment or severe child abuse or any of the above felonies committed, DCS must carefully consider if there are compelling reasons to make reasonable efforts to reunite this child/youth with the offender.
- The consultation with the DCS lawyer is critical before deciding that reasonable efforts are not required. Not only do the facts supporting the decision not to make reasonable efforts have to be carefully explored, but also the Court findings on the defined felonies. If the decision is made not to make reasonable efforts, then a motion must be filed with the juvenile court and an order obtained that reasonable

efforts are not required. If reasonable efforts are not required, there must be a permanency hearing within thirty (30) days. If the permanency hearing triggers the filing of a petition to terminate, DCS must file the petition immediately.

**(g) Other Instances When It Is Reasonable to Make No Effort to Reunify the Child/Youth and Parent**

- In addition to the above statutory exceptions to reasonable efforts, there are some cases in which lack of services to preserve or rehabilitate the family is reasonable. This means that even if there are no applicable statutory exceptions to the requirement to make reasonable efforts, it may be that after the assessment of the facts and the family situation, DCS may take the position that lack of efforts is reasonable efforts. For instance, in a severe child abuse case, an assessment of the injuries, circumstances and family constellation may result in the determination that the only viable permanency goal is adoption. It may be reasonable to make no effort to reunify the child/youth and family. After DCS has made that decision and established the goal of adoption, the Court must determine (within thirty (30) days of the decision) that the Department's assessment and decision are accurate and that its actions were appropriate.
- If the Court agrees with the decision, then the Court would find that the Department's efforts were reasonable (not that reasonable efforts were not required). If this is the finding, and the goal of adoption is approved, DCS would then proceed with the termination of parental rights.

**(6) Documentation**

- (a) All children/youth in foster care shall have a permanency plan which contains specific information about:
  - How a child/youth's permanency goal will be achieved
  - What services are necessary to make the accomplishment of the goal likely
  - Who is responsible for the provision of those services
  - When the services will be provided, and
  - The date by which the permanency goal is likely to be achieved
- (b) Major treatment issues for the child/youth and family (drug treatment, sexual offense victim or sex offender treatment, special education, domestic violence, etc.) that are identified during the assessment process shall also be noted in the permanency plan along with activities necessary to address the issues that brought the child/youth into care.
- (c) The permanency plan shall have clearly specified time frames for completion of activities and shall address issues raised as a result of all child/youth protective services investigative activities and the assessment protocol.
- (d) Specific tasks listed on the permanency plan shall include observable or measurable outcomes, as well as the names of the persons responsible

for completion of each task. This is to include responsibilities of the family and of the Department in provision of services and monitoring of progress, as well as the child/youth in regard to his/her issues of growth, development, awareness, behaviors, and emotional issues.

- (e) Documentation required by federal law to be included in the permanency plan includes the following:
- Efforts made by the Department to prevent removal of the child/youth and placement into custody
  - A description of the type of placement and plan for assuring that the child/youth receives safe and proper care in the least restrictive (most family-like) and most appropriate setting available and in close proximity to the parents' home, consistent with the best interest and special needs of the child/youth
  - A discussion of the safety and appropriateness of the placement
  - To the extent available and accessible, the health and education records of the child/youth
  - For a child/youth age 14 or above, the plan must also include a written description of the programs and services that will help the child/youth prepare for transition from foster care to independent living. These programs and services must be age and circumstance appropriate
  - For all children/youth the plan must document steps the Department is taking to achieve permanency for the child/youth. These steps should support the achievement of the permanency goal

**(7) Time Frames**

- (a) The permanency plan shall be completed within thirty (30) calendar days of the date the child/youth enters DCS custody.
- (b) The Juvenile Court of venue shall review and approve all permanency plans (unless the child/youth is placed in a YDC; when a youth steps down to a placement, court reviews begin). A DCS attorney shall file a motion for a hearing for ratification or approval of the plan and shall provide notice as required by law to all parties. The initial permanency plan is filed with the Court and copies are retained for the DCS file. Parties required to receive notice shall be advised by the case manager at least seven (7) days in advance if notice is by telephone, and at least ten (10) days in advance if notice is by certified mail, of the date the plan is to be presented to the Court. If parents or other legal custodians have disagreement with the plan, they shall have the right to present their concerns about the plan to the Court. Documentation of notification must be included in the case record and in the foster parent file.
- (c) All services documented as necessary for the achievement of the permanency goal or goals (Section 9, Column B of the Permanency Plan) shall be provided within the time period in which they are needed (Section 9, Column C of the Permanency Plan). The dates for services cannot be extended more than once except for extraordinary circumstances or when services address a chronic condition. The case

manager must document in the child/youth's record approval by the team coordinator of all extensions.

**b. Permanency Plan Revisions**

- c. All significant revisions of the permanency plan (including a change in goal, adding a relevant party such as a parent or resource family, addressing a newly disclosed need on the part of a child/youth or parent/former legal custodian) shall be the responsibility of the case manager and shall be undertaken within the context of a child and family team meeting. The child and family team meeting shall involve all significant individuals as outlined above in this policy. (Note: revisions constitute a new permanency plan.)
- d. Significant plan revisions may be made at any time and do not have to be made in conjunction with a Foster Care Review Board meeting or permanency plan hearing, although they must be made in the context of a child and family team meeting. Changes in the plan should be made when new problems hindering the accomplishment of the permanency goal(s) are identified, when there is a change in the permanency goal(s), when there must be a change in time frame/target dates, or when there is a need for changes in services or treatment for the child/youth or family. A change in a child/youth's placement (or in the needed level of care) does not necessarily, but may, indicate the need for a change in the permanency plan.
- e. Permanency plans shall be updated no less often than annually. Permanency plans must be reviewed through the quarterly progress review process (see DCS policy 16.32, *Foster Care Review and Quarterly Progress Reports*).
- f. All parties shall be consulted for possible agreement to meet on the earliest practical date, following the initial family meeting (DCS Policy 31.8, *Initial Child and Family Team Meeting*), for the original permanency plan child and family team meeting. If there is not an agreement, and/or if the child and family team meeting is not for the original permanency plan, notice must be given at least seven (7) days in advance of the child and family team meeting if notice is by telephone, and at least ten (10) days in advance if notice is by certified mail. Letters and telephone participation should be encouraged for those parties not in attendance.
- g. DCS staff shall be available to conduct child and family team meetings at times that support birth and foster families' and children/youth's work and school schedules. This may require scheduling meetings outside the state's standard 8:00 to 4:30 workday. The Department will assist the family in locating the services needed to facilitate the family's full participation in the child and family team meeting (i.e. transportation, childcare, and interpreters). Children/youth age 12 years and above must be

invited to participate in the child and family team meeting. Younger children may participate as appropriate.

- h.** As with the original plan, when revisions of the permanency plan are made, the plan must be presented to the court of venue in a hearing and approved by the court. As with the original plan, a parent or other legal custodian who did not agree with the revised plan shall have the right to present their concerns about the revised plan to the Court of venue during the hearing.

**a. Role of DCS Attorneys in Permanency Planning**

- (1)** DCS attorneys will be notified and may be invited to participate in permanency planning child and family team meetings. It may be determined that DCS attorney not participate in the child and family team meeting, however in this case, legal consultation should be sought by the case manager prior to the child and family team meeting.
- (2)** A DCS attorney shall review all permanency plans (initial and subsequent) prior to submission to the court for signature or ratification. The purpose of this review is to ensure that child/youth and family issues, services, and placement issues necessary to establish reasonable efforts findings at the initial and later court hearings are addressed.
- (3)** If the content is determined to be insufficient in detail (related to identified needs, services and/or responsible parties to the case) or the goal inconsistent with early permanency, the attorney will consult with the case manager and team leader and provide input and assistance to assure that all issues necessary to establish reasonable efforts and placement in the least restrictive alternative are presented at another child and family team meeting and negotiated and agreed to by the team and included in the plan prior to submission of the plan to the court.
- (4)** A DCS attorney is responsible for presenting the completed permanency plan to the Court of venue for approval by the court. A parent or other formal legal custodian, who did not agree with the plan, shall have the right to present their concerns about the plan to the Court of venue during the hearing. If all parties have not agreed to the plan, the DCS attorney will file a motion for a hearing and ratification of the plan.

**2. Setting Goals In Planning For Children in DCS Custody**

In planning for children, Providers shall, in cooperation with Departmental Staff:

- initially seek to work intensively with the child's parents, other appropriate family members and Departmental Staff to allow the child to remain safely at home, if appropriate
- in those instances in which removal from the home is necessary, will work intensively with the child's parents and other appropriate family members in a collaborative process to return the child home quickly under appropriate circumstances consistent with reasonable professional standards, and
- if return home is not appropriate or cannot be accomplished safely within a reasonable period of time, will assure the child an alternative, appropriate permanent placement as quickly as possible

- Set goals to ensure that the child receives an appropriate education in the least restrictive environment while in custody

### **3. Initial Family Meeting Within Seven Days of the Date of Custody**

The purposes of the 7-day meeting are:

- to discuss the problems that necessitated the child's removal
- to assess the appropriateness of the child's placement based on the reasons for removal, contacts with the child, contacts with the foster home or other placement, and all other available information
- to arrange an immediate visitation schedule between the child and the parents
- to identify possible relative placements
- to begin an assessment of the child's and family's needs, and
- to arrange for a schedule of contacts between the parents and the worker

### **4. Permanency Plan Staffing Within 15 Days of Date of Custody**

A permanency plan staffing shall occur within 15 working days of a child entering custody.

The purposes of the permanency staffing meeting are:

- to discuss the problems that necessitated the child's removal
- to identify the changes by the parents that may be necessary to allow the child to return home safely
- to identify the services that need to be provided to the parents to allow the child to return home
- to determine the appropriateness of the child's placement
- to arrange a visitation schedule between the child and the parents
- to ensure that all reasonable efforts will be made to enable the visitation to take place, and
- to arrange a schedule of contacts between the parents and the worker
- To involve all persons involved with the child in planning and services

### **5. Ongoing Assessments of the Case and Regularly Scheduled Permanency Plan Reviews**

The child's DCS case manager and supervisor shall have an ongoing responsibility:

- to assure that the child's permanency goal is appropriate or to change it if it is not
- to assure that the child's services and placement are appropriate and are meeting the child's specific needs
- to assure that the parents and other appropriate family members are receiving the specific services mandated by the permanency plan and that they are progressing toward the specific objectives identified in the plan, and
- to assure that any private service providers identified in the plan or with whom the child is in placement are delivering appropriate services

The child's permanency plan shall be reviewed at meetings at least at the following time periods:

- 6 months after the date the child entered custody
- 12 months after the date the child entered custody

- 15 months after the date the child entered custody
- 21 months after the date the child entered custody
- 24 months after the date the child entered custody, and
- every 3 months thereafter

These meetings are intended to address the responsibilities outlined above and must be separate and distinct from any court hearings, foster care review board meetings or other judicial or administrative reviews of the child's permanency plan.

## **6. Discharge Planning and Trial Home Visit Requirements**

DCS shall recommend to the court a **ninety (90)** day trial home visit for all dependent and neglect adjudicated children for whom a decision is made to return home or to be placed in the custody of a relative. A thirty (30) day trial home visit shall be recommended for delinquent youth.

A decision to return a child to his/her home or to be placed in the custody of a relative shall be made at a discharge staffing meeting for any child in state custody regardless of whether that child is to be released from state custody immediately upon return home or whether that child remains in state custody during a thirty (30) day or ninety (90) day trial home visit.

The discharge staffing meeting shall be attended by:

- the child's DCS case manager
- the case manager's supervisor
- the worker from the private agency if the child is placed with a private agency
- the foster parents (unless DCS determines that the foster parent's attendance would be inappropriate)
- the biological parents or relative who is assuming custody and the child, and
- other involved adults or other support or resource persons

DCS shall provide notice of the meeting to the guardian ad litem for the child if one has been appointed and to the court appointed special advocate (CASA) worker for the child if one has been appointed.

At the discharge staffing meeting, the participants will identify all of the services necessary to ensure that the conditions leading to the child's placement in foster care have been addressed, and that the child's safety will be assured, and will identify the services necessary to support the child and the trial home visit. DCS shall provide or facilitate access to all services necessary to support the child and the trial home visit.

During any trial home visit period, the child's case manager shall visit the child in person:

- at least three (3) times in the first thirty (30) days and
- two (2) times per month for the remaining sixty (60) days.

Each visit shall occur outside the parent's or caretaker's presence.

The case manager shall also contact service providers.

The case manager shall visit the school of all school age children at least once each month, shall interview the child's teacher, and ascertain the child's progress in school and whether the school placement is appropriate.

Before the end of any trial home visit period, there shall be a final discharge staffing meeting, which shall include:

- the child's case manager,
- the child, and
- the parent or relative.

The purpose of the final discharge staffing is to determine the appropriateness of a final discharge.

For staffings attended by a case manager I, the team leader shall be present at the meeting. Otherwise, the team leader shall document in the record approval of the decision to finally discharge the child or to seek an extension prior to the expiration of the trial home visit.

If final discharge is determined to be inappropriate, DCS shall make the appropriate application to the court to extend the child's placement in the custody of DCS before the expiration of the trial home visit period. Continuation of continuum services are allowable, as deemed appropriate for the child and family needs through the Staffing and Review Process.

## **7. Engaging Families**

DCS Case Managers shall engage families in helping relationships that will support the achievement of safety and permanency for children. These relationships shall be characterized by behaviors and actions that impart respect for human dignity, an appreciation for the knowledge and strengths that families and children possess, and knowledge of the appropriate use of authority in serving families.

### **a. Procedures**

#### **(1) Interpersonal skills**

DCS staff and Contract Providers shall interact with families and children using culturally competent, interpersonal skills demonstrating genuineness, empathy, and respect for the family and individuals.

#### **(2) Including families in key decisions**

**(a)** DCS staff and Contract Providers shall partner with children and families for case planning and decision-making in the course of conducting interviews and home visits, Child and Family Team Meetings, and through case staffings.

**(b)** The Child and Family Team Meetings and case staffings should include all of the key stakeholders in the case as jointly identified by the family, the Provider and DCS. Different persons may be needed or mandated to attend depending on the type and purpose of each individual meetings.

### **(3) Child and family team meetings**

The use of Child and Family Team Meetings throughout the life of a case serves as a primary vehicle for including families and children in case planning and decision-making. At a minimum, when a child is placed in state custody, these meetings shall occur:

- (a) Immediately after placement into state custody and no more than seven (7) working days from that date. See DCS Policy 31.8, *Initial Child and Family Team Meeting*.
- (b) Within fifteen (15) working days of the child's entry into state custody for the purpose of developing a permanency plan. See DCS Policy 16.31, *Permanency Planning for Children/Youth in DCS Foster Care*.
- (c) At critical decision points in the case including a change of permanency plan goal, discharge, or to review progress toward achieving the permanency plan goal. See DCS Policy 31.9, *Child and Family Team Meetings at Critical Decision Points and to Review Progress of the Permanency Plan*.

### **(4) Format for child and family team meetings**

The Child and Family Team Meetings shall, to the extent possible, include the following activities:

- (a) **Facilitating introductions** – The facilitator will introduce all persons present, give a statement of purpose for the meeting, and discuss confidentiality issues.
- (b) **Establishing ground rules** – The facilitator should take the time for the group to develop some ground rules for the meeting to manage emotions and to keep the meeting focused on the outcomes (e.g., speaking one at a time, using appropriate language and tone in responding, developing a process for calling “time out” when necessary, etc.).
- (c) **Encouraging meaningful child and family participation** – To the greatest extent possible, DCS shall support the child and parents/caregivers in sharing their story related to their current situation, defining their underlying needs and desired outcomes, and developing and approving selected options that will meet the underlying needs of the child and family. Family diagrams shall be drawn as a means to encourage the parents and the child to share information about relationships and possible resources for the family.
- (d) **Clarifying DCS's obligations and non-negotiable positions** – The facilitator must clarify for all participants that DCS is responsible for the safety of the child and for developing a plan that quickly moves the child to permanency. DCS must state the items that are “non-negotiable” in order to assure safety, achieve early permanency, and fulfill legal mandates.
- (e) **Identifying child and family strengths and needs** – The group shall work together to identify and acknowledge the family and child's strengths. Following strengths identification, the team will reframe the behavioral expressions of the problems requiring DCS intervention to identify the underlying needs of the child and family.

- (f) **Identifying targeted solutions to address the underlying conditions** – The group should brainstorm ways to meet the underlying needs of the family while maintaining safety and working towards timely permanency for the child.
- (g) **Developing the plan** – The group will develop a plan that meets the underlying needs and achieves the desired outcomes defined at the meeting. This agreement will be written by the facilitator using form *CS-0230, Staffing Summary and Placement Justification* and will include the assigned tasks and responsibilities of each participant. The written document shall be reviewed with and signed by the participating team members at closing.
- (h) **Troubleshooting potential setbacks** – The group will assess what might go wrong with the plan, who will notify DCS if a particular step in the plan fails, and how the parties will address the need for changes to the plan.
- (i) **Closing the meeting** – The written agreement will be reviewed with the team for accuracy, signed, copied, and distributed to each meeting participant. The next meeting date will be set, as needed.
- (j) **Documenting the team's work** – The meeting and outcomes shall be documented in the case recordings.

**(5) Accommodating families**

DCS staff and Contract Providers shall plan Child and Family Team Meetings and staffings for times that are convenient to the family and the children and shall hold meetings and staffings in convenient settings that are conducive to discussion of family issues.

**(6) Support services**

DCS staff and Contract Providers shall provide services to support parents and relatives in their participation in the team process. Such services may include transportation, childcare, interpreter services, and any other services that would support the family's participation.

**(7) Keeping families informed**

In the exceptional circumstance where an emergency decision is made that significantly changes a child's status and there is no time to confer with a family prior to the decision, the DCS Case Manager shall contact the family immediately in order to explain the situation, discuss why the change was necessary, and obtain feedback from the family related to the change.

**(8) Keeping children informed**

In the exceptional circumstance where an emergency decision is made that significantly changes a child's status and there is no time to confer with a family prior to the decision, the DCS Case Manager shall contact the child immediately in order to explain the situation, discuss why the change was necessary, and obtain feedback from the child related to the change.

## **8. Serving The Educational Needs of the Child In DCS Custody**

### **a. Application**

DCS staff, including home-county case managers, supervisory staff, team coordinators, and regional administrators, foster parents, and all children in DCS custody, regardless of placement type and all Contract Providers.

**b. Authorization**

T.C.A. 37-1-140; T.C.A. 37-1-130; T.C.A. 37-1-131; Individuals with Disabilities Education Act, 20 U.S.C. Sec. 1400 et. seq.; McKinney-Vento Homeless Education Act of 2001, 42 U.S.C. Sec. 11431 et. seq. ; Settlement Agreement Brian A. v. Sundquist;

**c. Policy**

All children in DCS custody will be educated in local public schools, except for those youth who have an identified and documented treatment need which would prohibit such an educational placement for a period of time. DCS must grant permission to any and all agencies desiring to operate an in-house school serving children in DCS custody. Educational programs must be approved by the Department of Education. These in-house schools or educational programs will serve only those youth whose public school service is prohibited for a limited period of time, due to the identified treatment needs of the youth.

**d. Procedures**

**(1) Responsibilities of the Case Manager**

For every child placed in DCS custody, the case manager shall complete the following:

- The DCS case manager shall collect, within one day of being assigned to the child's case, the child's educational records from the prior school, including the I E P, the psychological report, and the transcript. This information, along with the child's birth certificate, social security number, and immunization record, is necessary to either enroll the child in the next school, or schedule for a staffing, as outlined elsewhere in this policy.
- The DCS case manager or the agency school liaison shall prepare form letter CS-0000 to the school, identifying the foster parent and providing basic information to the school, and give the letter to the foster parents, or the agency school liaison, along with copies of the child's social security card, birth certificate, immunization records, and any other educational records available.
- The case manager shall ensure that the child is registered in school and that the foster parent has all necessary information and documentation to facilitate the registration process. The foster parent may enroll the child in public school (by transporting the child to the public school and meeting with school officials) with the case manager or solo, whichever is decided to be in the child's best interest and would result in addressing the child's educational needs. The foster parent will be considered the primary liaison with the school; the case manager will confirm that the school enrollment has taken place, monitor, and provide liaison services with the school.

- If a child is placed in an agency foster home, the DCS case manager and the agency case manager or liaison shall decide between them who is the best person to accompany the foster parent to enroll the child in school.
- If the child is determined to have special education needs and/or discipline issues, the case manager shall immediately bring the child to the attention of the regional educational specialist.
- If a child appears unlikely or has proven unable to function in public school, then the case manager must refer that child to the regional education specialist, who will work in coordination with the case manager, parents, foster parents, surrogate parents, etc to determine educational support and recommendations.
- The case manager must incorporate the child's educational goals as well as any related behavioral and/or medical concerns into the Permanency Plan, as well as any child and family treatment plan designed by agencies working with the child and family. Goals are written to insure that the child receives educational benefit while in state custody.
- The foster parent and the case manager must attend all IEP meetings and shall include the educational specialist and/or education attorney as appropriate and necessary. The education attorney will assist with disciplinary issues and negotiations with the local school system regarding the obligations of the school system.
- Whether the child is designated as special education or not, the case manager must communicate regularly with the foster parent and document such in the child's file regarding the child's educational progress and functioning. The Health Unit staff will be available to assist as needed.
- The case manager must ensure the involvement of the birth parents in the child's education, to the extent possible. For Special Education students, the school has the responsibility of involving the birth parents, in accordance with applicable laws.
- When notified by a foster parent that a youth is having behavioral problems at home and/or school significant enough to cause a future disruption of the youth's placement, the case manager should contact the DCS health unit immediately asking for assistance in obtaining in-home wrap around services for the youth and foster family. TennCare calls these services intensive mental health case management, CTT, or CCFT and they are available to children in DCS custody who are in level 2 placements or below.

**(2) Responsibilities of the Educational Specialist**

- The regional education specialist will consult with the local DCS staff, as well as contract agencies, regarding needed assistance, including general education training sessions for all staff.
- The regional education specialist will provide ongoing in-service training to the case managers and foster parents in their area.
- The regional education specialist will attend I.E.P. meetings as necessary to coordinate the appropriate educational services for the child.

- In the event a child in state custody is found to be ineligible for special education services, the regional education specialist will consult with the education attorney regarding the advisability of filing an appeal.
- When notified that a youth is having behavioral problems at home and/or school significant enough to cause a future disruption of the youth's placement, the educational specialist shall request that the case manager contact the DCS health unit immediately asking for assistance in obtaining in-home wrap around services for the youth and foster family. TennCare calls these services intensive mental health case management, CTT, or CCFT and they are available to children in DCS custody who are in level 2 placements or below.

### **(3) Responsibilities of the DCS Health Unit**

- The health unit nurse and/or psychologist shall attend IEP meetings when deemed appropriate by the DCS educational specialist.
- DCS TennCare Representative and/or health unit nurse will be available to assist foster parent, case manager, and educational specialist in accessing medically necessary health services (medical or behavioral health) identified by the school. If the youth is TennCare-Medicaid eligible, all medically necessary services are the responsibility of TennCare under EPSDT and the IDEA interagency agreement.
  - If the school identifies a need that may be medically necessary, the foster parent should call the youth's primary care physician or mental health provider for an interperiodic EPSDT screening. Many mental health providers refer to this type of screening as a clinical diagnostic interview. The health provider should be made aware of the services identified in the IEP.
  - From either the clinical diagnostic interview or the screening with the PCP, the child should receive recommendations for care. If these recommendations match those in the IEP, the case manager shall notify the school that these services will be provided by TennCare. If the services do not match those identified in the IEP, a Grier appeal must be filed and the health unit TennCare representative will assist with the filing of this appeal. While the appeal is pending, foster parents, the case manager, and the educational specialist (if needed) shall pursue the needed services through the school district.
- When notified by the case manager or foster parent that a youth is in danger of disrupting their placement due to behavioral problems, the DCS health unit will work with the case manager to obtain in home services for the youth and foster family. These services (called CTT or CCFT by TennCare) are available to all children in DCS custody in placements level 2 or below. These services may prevent disruption and allow the youth to remain in the same educational environment.

### **(4) Enrolling a Child in Public School**

- If the child is in a temporary, emergency type of placement, it is the Department's expectation that the child remains in his old school if at all possible. The local school system has the first obligation to provide transportation, under McKinney-Vento, but if they do not provide

transportation, this may mean that the case manager has to transport the child back and forth to the old school, until his/her placement is made in a more “permanent” setting.

- The Case Manager is responsible for giving the school the name of the contact person or liaison with the school.
- The Case Manager is responsible for maintaining basic demographic information, including copies of the child’s birth certificate, social security card, and immunization records on the child; and making this information available to the school system as needed to enroll the child in public school.
- It is the responsibility of the home county case manager to collect the educational records, and make sure that the old school (“sending” school) sends the official school record to the new school (“receiving” school) as soon as possible. While it is not an official school record, most school systems will accept DCS educational records, including birth certificate, social security card, and immunization records on the child until they can receive the official school record.
- If there are indicators that the child has educational deficits, the case manager and/or other DCS staff or agency staff, if agency care must ensure that a written request is submitted for educational evaluation (testing) for the child to determine the possible special educational needs of the child. It is preferable that the request is made by the foster or birth parents. The DCS case manager will encourage or facilitate the consent process by the biological parents in order to move the process forward. If the birth parent is unknown or unavailable, the case manager should consult with the educational specialist regarding obtaining a surrogate parent.
- If a child is later determined to be ineligible for special education services, the educational specialist shall request the educational attorney to review the findings.
- When a youth in a foster parents home is having behavioral problems at home or school significant enough to cause a future disruption of their home, the foster parent shall contact the home county case manager immediately and request assistance in obtaining in-home wrap around services for the youth and foster family. TennCare calls these services intensive mental health case management, CTT, or CCFT and they are available to children in DCS custody who are in level 2 placements or below.

#### **(5) Education Plan for Children Placed Temporarily**

- DCS and Agency Foster Homes
  - If a child is placed in an emergency foster home, again the expectation of the Department is that the child remains in his former school, if at all possible.
  - Again the local school system has the first obligation to provide transportation under McKinney-Vento; but if the school system cannot, then it is the responsibility of the case manager or the foster parents to transport the child back to the former school.

- Otherwise, that time period (three days) must be used to develop an educational assessment for the child. Persons to be included in the staffing are the Case Manager, the biological parents, the foster parents, the Educational specialist, and any other professionals having knowledge of the child’s situation. It is the responsibility of the home county case manager to convene the staffing.
- In the rare instance that a child has been excluded from public school and cannot be readmitted in another school setting and/or the foster home will disrupt if the child cannot be placed in another school setting, i.e. alternative school, within the LEA, then the DCS case manager should consult with the educational specialist, and a waiver from the public school presumption may be requested from and considered by the Regional Administrator following the staffing.
- The Home County Case Manager will consult with their Regional Administrator regarding the “Temporary Alternative Educational Placement” in the event the child is unable to return to public school. Any request for such a waiver will be submitted to the regional administrator for review, and the regional administrator will forward to the Office of Compliance for final approval. The Home County Case manager, who can seek input from appropriate professionals, must develop an alternative educational plan.
- Emergency Shelters
  - If a child is placed in an emergency shelter, all possible attempts must be made to keep him in his former school, including extraordinary travel by the case manager to transport the child back to the former school, if the local school system is unwilling to fulfill their obligations under McKinney-Vento
  - If a child is placed in an emergency shelter and the child is not able to attend public school, this time period (30 days for a shelter) must be used as an educational assessment period by the agency, the case manager, and the Educational Specialist.
  - The Home County Case Manager will, within 3 days of placement at the shelter, convene a staffing with the health unit psychologist, health nurse, educational specialist and case manager to review education records, medical records, and any other available information. The purpose of the day 3 meeting is to design an interim education plan that will begin immediately.
  - The agency will develop an education plan to allow the child to complete remedial or ongoing work during the remainder of the child’s stay. The agency is responsible for follow-up to see that the services are being provided by a certified special education teacher.
  - If any child needs tutoring, then those services may be made available through the use of flex funds. All available community resources must be utilized to re-enforce and support the child’s appropriate placement. The case manager shall request assistance from the regional health units as appropriate and necessary.

- At the end of the placement in the emergency shelter, agency staff and DCS education staff will provide to the DCS Home County Case Manager any recommendations for future evaluations and educational programs.

**(6) Procedures When the Child is Unable to Attend Public School**

- While it is generally in the best interest of the child to attend public school, there are those rare occasions when public school attendance is not possible. In those instances, the treatment plan must document why public school attendance is not appropriate.
- If the child requires an in-house educational program or other alternative, the child may be in that educational setting up to thirty (30) total days.
- Prior to the end of the thirty-day limit, the Home County Case Manager must schedule a staffing. The staffing must include the Home County Case manager, agency representative(s); the foster parents, any individual with educational rights, educational specialist and/or attorney, health unit staff, and other professionals as necessary and appropriate.
  - During the staffing, a consensus will be reached regarding the educational services that will best meet the needs of the child and his/her treatment plan. If the consensus indicates that the child should continue to receive services at an in-house school or other alternative to public school, the treatment team will establish the specific treatment issues that require the child to be in the in-house school and provide a review and target date for completion of the treatment and projected date for transition to public school. The reasons for such placement and the goals of such educational services must be included in the documentation, along with an expected duration or time frame.
  - If no consensus regarding the most appropriate educational setting is reached at the staffing, the Home County Case Manager and the Educational Specialist will, within 3 days of the staffing, present the case directly to the Regional Administrator for a decision.
- The following reasons are some examples that a child would be unable to attend public school, and subsequently need to be served in an in-house school or other alternative educational plan:
  - Youth with current identified alcohol and drug treatment issues that require a self-contained treatment program
  - Youth with identified sexual offending treatment issues that require self-contained program
  - Youth for whom zero tolerance issues prohibit enrollment despite involvement and efforts of the educational specialist and/or attorney
  - Youth placed in wilderness programs in which the treatment regime is so integrally related to the educational program that attendance at public school would disrupt treatment

- Youth with crisis requiring intensive supervision due to community or child-safety treatment needs or at imminent risk of disruption of placement within this service
- Children who are in a hardware secured, enhanced staff
- In addition, the following circumstances may be cause for approval of a waiver from attending public school so that the youth can be enrolled in alternative education programs:
  - Youth aged 17 and up who are appropriate and eligible to take the G.E.D.
  - Youth eligible for and desiring enrollment in vocational or journeyman training
  - Youth who have graduated from high school or achieved a G.E.D.

**(7) On-Site School Requirements**

On-site schools will be monitored by the Department of Education (DOE) according to a monitoring cycle established by the DOE and the Department of Children Services education division staff. A copy of the Provider's on-site school approval letter from the Department of Education (School Approval and Accreditation) stating that the school is approved for both General and Special Education programs for the current school year shall be submitted to DCS Resource Management Residential Services Division. **If an agency has a contract for an in-house school, DOE school approval must be verified by DCS.** The following information should also be submitted: a list of all teachers in the school including their names, endorsement areas, and type of teaching certificate held. If any of the listed teachers are on a teaching permit or waiver, this should be indicated.

The Provider stipulates that the on-site educational program meets the following criteria:

- (a) All students are transient in attendance which means that they may be in attendance for less than the full 30 school days
- OR --**
- (b) The Provider established the agency's program for the primary purpose of providing residential care for children. The educational program is secondary to the primary goal of residential care.
- (c) The Provider agrees to meet Rules, Regulations and Minimum Standards (RRMS) in the following areas:
  - Special Educational requirements (0520-1-3-.09)
  - Length of school year (0520-1-3-.03(1)(a))
  - Attendance policy/laws (TCA 49-6-3001)
  - Fire Marshall's report (0520-7-2-.06(1)(f))
  - Inservice (0520-7-20.03(7)(c)12(ii))
  - Library materials collections (0520-1-3.07(3))
  - Records and reports (0520-1-3.04(4))
  - Report cards to parents (0520-1-3-.06)
  - Graduation requirements (0520-1-3.06)
  - Student health services (0520-1-3.08(4))

- Length of school day and class period (0520-1-3(2))
- (d) The Provider further agrees to meet the following minimum requirements:
  - Teacher certification
    - All teachers must hold a Tennessee Teacher's License or permit;
    - Special Education students must have special education instruction by appropriately endorsed teacher(s)
    - Elementary school (K-8) teachers must have appropriate elementary endorsement
    - Secondary school (7-12) teachers must have Tennessee Teacher's License or permit
  - Each agency shall develop procedures for evaluation of all professional school personnel.
  - Curriculum
    - The Individual Education Plan (I.E.P.) for each Special Education student must be followed
    - All course offerings must meet state standards for curriculum frameworks and guides
    - The school should continue the curriculum of each individual student; established by the base school that the student previously attended
  - Facilities
    - Provisions of a book center at the program site with appropriate reading materials for the age span and reading abilities of the children in the program. If the facility is located in an area served by a public library or a library on wheels, the program can supplement the book center with books from the library.
    - All appropriate building codes, EPA standards, and safety standards in general must be met. All local, state, and federal building and site codes must be followed.
  - Textbooks and Instruction Materials
    - Textbooks and individual materials for each student must be appropriate for the curriculum. The ideal situation for a greater individualized education program is accessibility to computers with software that can assess the child's basic skills and give the child an opportunity to work on individualized educational curriculum.
  - The Provider shall facilitate enrollment of a child in public school if that child can function in the classroom and it is in the child's best interest to attend public school. Such a decision shall be made jointly by the Provider and the Legal Educational Agency (L.E.A.) Youth enrolled in public school may not be billed through this contract.
  - Payment for educational services is calculated as follows:  
For each child serviced, the Provider shall multiply the service unit rate by the number of days that the child actually received services.

### **(8) Home Schooling**

- Home schooling of children in state custody is not permitted unless the DCS and the foster parents have signed an Adoptive Placement Agreement.
- In the event staff has extraordinary requests for home schooling, they may be presented to the Director of Foster Care or his/her designee in writing for a possible waiver of foster care policy on education.

### **(9) Training**

- Each foster parent is required to have two hours of in-service training per year in education.
- Each case manager working in the area of foster care is also required to have two hours of in-service training per year on educational issues.
- Training may be made available through the regional training coordinators and the regional educational attorneys and specialists.

## **F. PERSONNEL ISSUES**

### **1. Staff Definitions and Qualifications**

Specific criteria for hiring, training, and promoting shall apply to all case managers and supervisors with direct responsibility for the cases of foster children, both at DCS and at any contract agency. The Brian A Settlement Agreement requires specific maximum limits on the number of individual cases that may be assigned to a case manager and specific maximum limits on the number of workers supervised by supervisors. All case files shall contain adequate and timely documentation tracking the services provided, progress, any change in the placement of the child and authorizations which document the approval for placements, treatment and services provided to each child.

Although private childcare agencies use a variety of position titles to identify individuals who have like responsibilities, the following definitions will be used to establish uniformity.

### **2. Staff Qualifications for Agencies Providing Residential Services (Group Homes and RTCs)**

See Foster Care Section for foster care agency requirements.

**ALL VOLUNTEERS WITH DIRECT CONTACT WITH YOUTH MUST HAVE THE SAME SCREENING, BACKGROUND CHECKS, AND FINGERPRINT CHECKS COMPLETED AND ON FILE AS STAFF.**

#### **a. Program Director**

**Definition---**The Program Director is located on site and is responsible either directly or indirectly through delegation for the following responsibilities:

- Agency planning
- Budget preparation
- Recruitment, selection and hiring of employees
- Training
- Interpretation of the agency's program to the community
- Implementation of the agency's policies and procedures

In small programs, the Program Director may also be responsible for providing treatment or supervising treatment staff. In this situation (or any other in which a staff member fulfills the roles/responsibilities of more than one position) the Program Director must meet all the qualifying requirements for the position that typically has that job responsibility.

**Qualifications of Program Director**---must have a minimum of a **Bachelor's degree** in the social sciences, business, education or an allied field. A minimum of **two (2) years** of experience working in a childcare agency is required. Experience in a residential setting is preferred. Program management experience is desirable.

#### **b. Clinical Service Provider**

**Definition**---The Clinical Service Provider is an appropriately licensed or certified professional who may work directly with children and families or may serve as treatment and program consultants to the agency's and casework supervisor staff. This individual may be on-staff with the agency or may be a contracted service provider.

**Qualifications of the Clinical Service Provider**---must be appropriately licensed or certified and be a medical doctor or have a **Master's degree, Ed.D, Ed.S, or Ph.D.** in the behavioral sciences with a minimum of **three (3) years** of pertinent work experience since receiving the advanced degree. Five years of pertinent experience is desired. The Clinical Service Provider's area of concentration or experience should be appropriate to the issues of consultation. An individual with a Master's degree who is on a licensure tract and under the supervision of a licensed practitioner is acceptable as a clinical service provider. All required documentation for licensure tract and supervision should be included in the personnel file of the Clinical Service Provider.

#### **c. Casework Supervisor**

**Definition**---The Casework Supervisor may be a full-time employee of the agency or a part-time contracted employee. Responsibilities include:

- Providing role model for children
- Encouraging/assisting children in the practice of proper hygiene
- Transportation of children
- Assisting s by reporting significant events that occur during the shift
- Assistance in crisis intervention
- Oversight/supervision of casework staff

- Training of staff

**Qualifications of Casework Supervisor**---with supervisory responsibility for case managers or caseworkers shall have a minimum of a **Master's degree** in social work or related behavioral field with a child or family focus (excluding criminal justice) and at least three years experience as a caseworker in child welfare; however, an additional 2 years of providing child welfare services may substitute for the master's degree (This sentence does not apply to supervisors currently holding their positions as of October 1, 2001.)

#### **d. Caseworker**

**Definition**---The Caseworker is generally a full-time employee of the agency working on site. Some agencies may contract for part-time casework services. The Caseworker may be the "front line" worker with children in some facilities. Caseworker responsibilities include:

- Participation in the development of treatment plans
- Implementation of individual treatment plans (if applicable) for the children and/or families
- Maintenance of casework documentation and progress notes
- Therapeutic support to children regarding educational goals, anger control, grief issues, separation issues, and other personal and family issues
- Provision of crisis intervention
- Transportation of children
- Facilitation of group process and structured treatment activities

**Qualifications of the Caseworker**---must have a minimum of a **Bachelor's degree** with a major in social work or a related field such as psychology or sociology and **one (1) year** of pertinent experience in the human services field with children or in a residential treatment setting. Volunteer experience, practicum and intern experiences in programs/facilities that work with children and families may be counted as pertinent work experience. A Master's degree in the social sciences may be substituted for the one year of work experience.

**Qualifications of Case Manager 1**---shall have a Bachelor's degree in social work or related behavioral science.

**Qualifications of Case Manager 2**---shall have at least a Bachelor's degree in social work or related behavioral science and one year experience in providing child welfare services.

**Qualifications of Case Manager 3**--- shall have at least a Bachelor's degree in social work or related behavioral science and two years experience in providing child welfare services. A master's degree in social work or related behavioral science, may substitute for one year's experience in providing child welfare services.

#### **e. Child Care Worker Supervisor**

**Definition---** In most agencies, the Child Care Worker Supervisor is the direct supervision of the child care workers. The Child Care Worker Supervisor responsibilities include:

- Providing role model for children
- Supervision of direct care staff and children
- Participation in and supervision of recreational activities
- Assisting in the preparation of meals and the supervision of children during meals
- Encouraging/assisting children in the practice of proper hygiene
- Transportation of children
- Assisting s by reporting significant events that occur during the shift
- Assistance in crisis intervention

**Qualifications of the Child Care Worker Supervisor---**must have an **Associates degree** with emphasis working with children. **One (1) year** of experience working in a children's services program is required with experience in a residential setting. Two additional years working in a residential setting with children may account for the Associates degree.

**f. Child Care Worker**

**Definition---**In most agencies, the Child Care Worker provides the direct supervision for children. The Child Care Worker's responsibilities include:

- Providing a role model for children
- Supervision of children in completing household chores
- Participation in and supervision of recreational activities
- Assisting in the preparation of meals and the supervision of children during meals
- Encouraging/assisting children in the practice of proper hygiene
- Transportation of children
- Assisting s by reporting significant events that occur during the shift
- Assistance in crisis intervention

**Qualifications of the Child Care Worker---**must have a **high school diploma or a GED**. **One (1) year** of experience working in a children's services program is recommended, preferably with experience in a residential setting. Volunteer experience, practicum and intern experience in programs/facilities that work with dysfunctional children and families may be counted as pertinent experience. Any of the following may be substituted for the one year of work experience: an Associate's degree with at least twelve (12) semester hours (18 quarter hours) in the social sciences; two (2) years of college education in a general college curriculum [which includes at least twelve (12) semester hours (18 quarter hours) in the social sciences]; or, a Bachelor's degree with at least twelve (12) semester hours (18 quarter hours) in the social sciences.

**It is the obligation of the Provider to ensure and document that an intensive training program (to include all hours and core topics specified in the manual as a minimum) is completed by the employee prior to the initiation of independent direct care service, and close monitoring and supervision of such**

**employee by experienced staff during the first year of employment is clearly documented in the employee personnel file.**

### **3. Caseload, Supervision and Agency Caseworker Visits**

Where Provider's Case Manager role mirrors that of a DCS Caseworker with foster care and in home services, the following supervision of caseload requirements apply. This does not include direct care staff.

- No Case Manager 1 or agency job class equivalent having responsibility for the case of any class member shall have a case load totaling more than 15 class members
- No Case Manager 2 or 3 or agency job class equivalent having responsibility for the case of any class member shall have a case load totaling more than 20 class members
- Case Managers or agency job class equivalent with an adoptions caseload shall not have a caseload totaling more than 12 children who are adjudicated dependent/neglected or unruly
- Case Manager 3s or agency job class equivalent having no supervisory responsibility shall not have a caseload of more than 20
- Case Manager 3s or agency job class equivalent that supervise shall have a weighted caseload
- Case Manager 3s or agency job class equivalent supervising up to two lower level Case Managers or agency job class equivalent shall not have caseloads totaling more than 10. A Case Manager 3 or agency job class equivalent supervising three or more lower level Case Managers or agency job class equivalent shall not have a caseload.

A Case Manager 3 or agency job class equivalent shall not supervise more than 4 Case Managers or agency job class equivalent. Case Manager 3s or agency job class equivalent shall be given supervisory responsibility only in circumstances in which the caps on supervisory caseloads dictate that an additional Case Manager 4 or agency job class equivalent would have less than a full supervisory case load.

For children in a foster home or facility operated by a contract agency DCS shall require and ensure that the private agency caseworker visits the child as frequently as necessary to ensure the child's adjustment in placement, to ensure the child is receiving appropriate treatments and services, and to determine that the child's needs are being met and service goals are being implemented. Visits may take place in the child's placement, at school if the child is of school age, in the case manager's office, or in another appropriate setting. Worker-child visiting shall mean a face-to-face visit between the child's agency caseworker and the child. Visits shall include a private meeting between agency caseworker and the child out of the presence of the foster parents or caretaker, except for those cases in which the child is an infant. **There shall be at least 6 face-to-face visits during the first 8 weeks a child is in a new placement, and at least 3 of these visits shall take place in the child's placement. During the second 8 weeks the child is in a new placement, there shall be at least 1 face-to-face visit every 2 weeks. Following the first 16 weeks a child is in a new placement, there shall be at least 2 face-to-face visits each month.**

#### **4. Verification of Employees' Qualifications Applies to Residential Contract Agencies and Foster Care**

The Provider must have in the employee's personnel file and available for review this information on each employee prior to initiation of employment:

- Diploma(s) and/or transcript(s), as required for the particular position
- Driver's license(s)
- Driving record background check
- Police record check (criminal record background) inclusive of last 5 addresses through a National Search
- Fingerprint cards
- All contract agencies that perform services for Department of Children's Services through a contractual relationship are required to provide fingerprint checks. Fingerprinting shall be conducted on all new employees, foster parents and adoptive parents at the time of employment (reference: Administrative Policies and Procedures 4.22). All fingerprint checks should be verified within the new employees probationary period. New employees are eligible to begin work if appropriate background checks have been completed with pending verification of fingerprint checks. Fingerprints checks are separate from the required criminal background check which agencies are currently administering before hiring a new employee.
- The TBI has now posted a listing of convicted sex offenders on the Internet ([www.ticic.state.tn.us](http://www.ticic.state.tn.us)). Current employees as well as prospective employees and/or agency volunteers must be checked against that list, with documentation made in the employee's/applicant's file of the date this information was accessed. Any individual appearing on this list would not be appropriate for employment in a children's services program. A form entitled SEX OFFENDER REGISTRY VERIFICATION has been developed for such documentation. The form copy follows this page in the manual. A copy must be on file for each staff and volunteer verifying check.
- Any professional license and/or certification applicable to a specific job position
- All contract agencies that perform services for the Department of Children's Services through a contractual relationship are required to check prospective employees and/or agency volunteers against the Elderly or Vulnerable Abuse Registry. The Tennessee Department of Health is required by state law and federal regulations to registry of persons who have abused, neglected, or misappropriated personal property. The address for the Elderly or Vulnerable Abuse Registry is as follows:
  - Tennessee Department of Health
  - Elderly or Vulnerable Abuse Registry
  - 1<sup>st</sup> Floor, Cordell Hull Building
  - 425 Fifth Avenue North
  - Nashville, TN 37247-1010
  - <http://www2.state.tn.us/health/AbuseRegistry/index.html>

All persons applying for positions with DCS or a contract agency which involve any contact with children shall be required to submit to a criminal records check and a child abuse registry screening process (before beginning training or employment). No DCS or contract employee who has any contact with children shall have been convicted of a prior felony for any offense designated as a crime against the person or have been the subject (i.e., alleged perpetrator) in any substantiated or indicated case of child abuse or neglect. An individual who has been convicted of any prior felony may not be employed by DCS or contract agency in a position involving contact with children unless:

- The conviction occurred at least 5 years prior to the employee's hiring;
- The employee has not been convicted of any other criminal offense since that conviction;
- The DCS Regional Administrator or agency program director personally reviews the circumstances of the applicant and determines that this employee could work productively and constructively with children.

An individual who has been convicted of any prior misdemeanor may not be employed by DCS or a contract agency in a position involving contact with children unless the last two criteria above are satisfied. If, however, any employee for whom the above criteria has been satisfied is the subject of a criminal conviction or becomes the subject in any substantiated or indicated case of child abuse or neglect during his/her employment, the employment shall be immediately terminated. The section is not applicable to employees convicted of delinquent offenses. This provision shall not apply to foster and adoptive parents.

## **5. Staff Training**

### **a. Case Managers and Case Manager Supervisors Pre-service and in-service training requirements**

Where casework activities mirror the duties of the DCS case manager, the agency training curriculum will correspond with DCS pre-service and in-service training. As a minimum, 80 hours of pre-service instructional training and 80 hours of pre-service supervised field training. Forty (40) hours of ongoing training each year is required for each staff.

The contract agency must have a written training plan with curriculum and material for staff pre-service training. The agency will have on file an annual in-service plan which will include specific topics and resources to comply with the plan. Services and staff training provided must be culturally competent, recognizing and respecting the cultural and ethnic heritage of the children and families served.

**The training plan for both pre-service and in-service training for the two staff classifications noted above must be submitted to DCS, Training Division for review and approval.**

The contract agency must provide and properly document in each Case Manager's and Case Manager Supervisor's personnel or training file, the following hours of training.

**(1) Case Manager:**

- Eighty (80) hours of pre-service instructional training
- Eighty (80) hours of pre-service on-the-job or supervised field training
- Forty (40) hours of on-going in-service training annually

**(2) Case Manager Supervisor:**

- Forty (40) hours supervisor training before assuming duty as Case Manager. All 40 hours must be completed and documented within the first 90 days.
- Twenty-four (24) hours in-service annually

**(3) Supervisor:**

- Twenty-four (24) hours in-service annually

Core training topics during pre-service orientation must include but are not limited to the following. All topics must include "Brian A." specific information where applicable. Department of Children's Services On the Job Training (OJT) material can be accessed at <http://preservice.snorps.utk.edu> password: "training manuals."

**(4) Pre-service**

- Health and Safety
  - precautions for suicide/self-harm intervention
  - treatment and handling of youth at risk for suicide or self-harm
- DCS Policies (applicable)
- Provider Policies (applicable)
- Information on the "Brian A. Settlement Agreement"
- Legal Issues
- Confidentiality
- Therapeutic Milieu
- First Aid and CPR
- Child Abuse Reporting
- Crisis Intervention

**NOTE:** This training must be provided through a nationally certified program such as Crisis Prevention Institute or Cornell's Therapeutic Crisis Intervention with appropriately credentialed trainers and must emphasize de-escalation techniques.

- Significance of Families
- Child Development
- Impact of Separation and Loss
- Teaching Self Discipline
- Communication Skills
- Professional Growth and Development

No case manager shall assume full responsibility for a case, except as part of a training caseload, until completion of training.

Agency and individual members of TACC receive notification of all trainings. TACC can be contacted at (615) 385-4433.

**b. Foster Parents**

**(1) Low intensity treatment foster care foster parents**

Low intensity treatment foster care foster parents shall be trained a minimum of thirty (30) hours, it is preferable that the PATH training program currently being utilized by the State's DCS Foster Care division be utilized prior to the placement of children, and another fifteen (15) hours within ninety (90) days of placement. A minimum of ten (10) hours of in-service training hours per year shall be required for all approved foster parents at this level. *(This includes the first year.)* The 10 hours required in-service training for newly approved foster parents (to be completed within one year of the approval) should include advanced courses on discipline, sexual abuse, and cultural diversity. (see Policy 16.4 in Appendix E).

**(2) Specialized/therapeutic foster care foster parents**

Therapeutic foster parents shall be trained a minimum of forty-five (45) hours (15 hours in addition to the number of training hours required in the PATH foster parent training program that is currently being utilized by the State's DCS Foster Care division) prior to placement of a child in their home. Core hours should be PATH training. The additional fifteen (15) training hours required for therapeutic foster care involve specialized training necessary to competently care for the greater needs of the foster children at this level. A minimum of fifteen (15) hours of in-service training per year will be required for approved foster parents. *(This includes the first year.)* Ten (10) hours of the in-service training hours for newly approved foster parents (to be completed within one year of the approval) should include advanced courses in discipline, sexual abuse, and cultural diversity.

**(3) Medically fragile foster care foster parents**

Medically fragile foster parents must receive training a minimum of forty-five (45) hours (15 hours training in addition to the number of hours of foster parent training hours required in the PATH foster parent-training program currently being utilized by the State's DCS Foster Care division) prior to placement of children. This initial training must include CPR and first aid training and specialized training on the special medical needs of each child to be placed in their home. Twenty (20) hours of in-service training is required annually for all approved foster parents at this level. *(This includes the first year.)* Newly approved foster parents (within one year of the approval) must receive fifteen (15) hours of in-service training to include advanced courses in discipline, sexual abuse, and cultural diversity.

**c. All Other Direct Service Staff**

- Thirty (30) hours of pre-service orientation/training
- Thirty (30) additional hours of in-service training during the first year of employment
- Twenty-four (24) hours of ongoing in-service training annually for all staff who have completed their first year of employment

Core training topics during pre-service must include but are not limited to the following:

- Health and Safety
- DCS policy on suicide and self-harm (19.1)
- DCS policies (applicable)
- Provider policies (applicable)
- Information on Brian A. Settlement Agreement
- Legal Issues
- Confidentiality
- Child Abuse Reporting
- Therapeutic Milieu
- And other topics as needed or applicable to the agency

**d. Substitution of required pre-service and in-service**

College credits in an applicable social science area earned within the current year may be substituted for annual training in the following manner:

- Two and two-thirds training hours per each quarter hour of college credit completed
- Four training hours per each semester hour of college credit completed

A new employee who is hired within a one (1) year period after having left employment with another contracted children's services agency, may be credited with the training hours received from the prior agency, toward the employee's current training requirements, upon documentation of the previous training.

An employee who has resigned in good standing from the Provider's program and is rehired within one (1) year of the resignation is not required to repeat the pre-service training and in-service training if these were previously completed. However, the annual ongoing in-service training requirement must be fulfilled.

**ADDITIONAL TRAINING MAY BE REQUIRED AND IS STRONGLY RECOMMENDED FOR SPECIALIZED PROGRAMS.**

**6. Staff Prohibitions**

Staff will not be permitted to take a child home on an overnight basis or for any other reason(s) including working in staff's home(s). On such very special occasions as Christmas holidays, staff members may take a group of no less than two (2) children home for holiday-related activities. On such occasions a male and female adult must be

present and prior written approval at least one week in advance must be granted by the DCS case manager.

Compliance with any/all other prohibitions as specified in the Provider's contract must be maintained.

NOTE: The contract agency must not encourage nor in any way suggest to parents/guardians of a non-custodial child that the child should be put in custody in order to receive services. If the agency is approached by the parent/guardian, and the agency does not serve non-DCS children, the contract agency Provider should refer the parent/guardian to the BHO or to the DCS Regional Health Unit. The contract agency Provider must not suggest custody by indicating the agency only serves custody children and not providing the parent/guardian with additional information.

## **7. Placement and Supervision of Children**

Exceptions in the best interest of the child shall apply under which the Regional Administrator will be allowed to make an exception. Exceptions will be made on an individual basis. A copy of an exception must be in the contract agency's child's case file which will be monitored by Finance and Administration. Exception request must be forwarded from the Home County Case Manager and must be given prior to placement in a situation requiring an exception.

Exceptions must be given related to placement of foster children in the following situations:

- All children shall be placed within their own region or within a 75 mile radius of the home through which the child entered custody
- Children shall not remain in emergency or temporary facilities for more than 30 days and shall not be placed in more than one emergency or temporary placement within any 12 month period
- Siblings who enter placement at or near the same time shall be placed together
- No child shall be placed in a foster home if that foster home will result in more than 3 foster children in that home or a total of 6 children, including the family's natural and/or adopted children
- No child under 6 years of age shall be placed in a group care, non-foster family setting
- No child shall be placed in any group care setting (group setting with more than 8 youth) without express written approval of the regional administrator

## **G. SUBCONTRACTS**

Providers using subcontractors for providing any type of direct services to children and/or families will develop a written master subcontract describing how the services are to be used and monitored with documentation of monitoring per Provider Policy Manual. The Contractor is responsible for the monitoring of the Subcontractor. All subcontracts must

meet standard state licensing contract requirements and hold a valid license for the fiscal year of subcontract.

### 1. Master Subcontracts

- All Master subcontracts can be valid up to one fiscal year (**July to June**). All subcontracts are to be renewed each fiscal year.
- All Master subcontracts and monitoring plans must be routed to the Director of both agencies for review and signatures.
- After both contracting agency signatures are obtained, subcontract(s) must be forwarded to the Residential Continuum Monitoring Unit, Department of Children's Services, for review and final approval **PRIOR TO** placement and/or use of subcontractor. State employees shall not be subcontractors.
- Contractors are responsible to insure the Subcontractor receives training on the DCS Provider Policy Manual and adheres to all DCS Policy as mandated by the Provider Policy Manual.
- The Subcontractor must submit any Serious Incident Reports (SIR) as required in **Appendix C** and to the Contract agency.

### 2. Individual Service Agreements

- **PRIOR** to submitting Individual Service Agreements (ISA), Contracting Agencies must have an approved Master Subcontract on file within the current fiscal year with Residential Continuum Monitoring Unit, Department of Children's Services.
- Contracting Agencies submitting ISA's must have current dates and signatures from both the Contractor and the Subcontractor **PRIOR** to forwarding to the Residential Continuum Monitoring Unit, Department of Children's Services, for review.
- ISA's must be submitted within a timely manner. Residential Continuum Monitoring Unit, Department of Children's Services, will review and verify information submitted by the contract agency.
- ISA's must be accompanied by the most recent Decision Making team summary or Treatment Team summary and Summary & Justification Page of Permanency Plan and/or Notice of Action. A staffing is required with any change in the method of service delivery, level of treatment, or step-down **PRIOR** to requesting an Individual Service agreement.

## H. TRANSPORTATION

The Provider maintains the primary responsibility for and must be willing to provide transportation to children in the program, including transportation to all medical/dental appointments and juvenile court appearances providing such appointments are within sixty (60) miles (**one way**) of the Provider's program. The Provider is expected to work with the Department of Children's Services and/or other designated agencies to assure that all transportation needs of the child are met. It is the Provider's responsibility to transport children for emergency treatment.

The following requirements must be met:

- All vehicles must be maintained and operated in a safe manner. (This includes the vehicles owned by the facility and/or by an employee if the employee provides transportation in his/her privately owned vehicle.)
- Staff providing transportation must possess a valid driver's license from their state of residence. For out of state contracts, the driver's license must be from the state where the program is located. Documentation of the license is to be maintained in the facility's records.
- All facility-owned and staff-owned vehicles used for transportation of children/youth must be adequately covered by medical and vehicular liability insurance for personal injury to occupants of the vehicles. Documentation of such insurance coverage must be maintained in the facility's records.
- Appropriate safety restraints must be used as required by State and Federal law.

## **I. REPORTING OF INCIDENTS**

The Provider will adhere to all incident-reporting practices as specified in the Department of Children's Services Incident Reporting Manual. A copy of the portion of the Incident Reporting Manual applicable to contract agencies may be found in Appendix C at the back of the Provider Policy Manual. All matters of abuse or neglect of foster children in DCS custody shall be investigated by the child protective services unit in the manner and within the time frame provided by law. All matters concerning abuse or neglect of foster children in DCS custody in institutional, group, residential or contract agency foster home placements shall also be referred to and reviewed by the Residential Monitoring Continuum Unit and, as appropriate, the licensing division. Additionally, alleged abuse or neglect concerning children placed with any contract agency shall be reported to the central office resource management unit and the quality assurance unit. DCS shall incorporate these reports, and their findings, into the annual review of each contract agency. DCS will evaluate carefully those reports and consider prior corrective actions, the history of the agency and determine if there are serious problems that place children at serious risk of harm and prevent further contracts from being issued.

## **J. BEHAVIOR MANAGEMENT**

### **1. Definition**

Behavior management is a process of identifying behavior(s) that needs to be changed or reinforced, identifying what is reinforcing or aversive to the individual needing to change, and systematically using consequences to elicit the desired behavior or to eliminate the undesired behavior. Restrictive behavior management is a procedure that limits the rights of the individual for the purpose of controlling or modifying problem behaviors and seeks to replace them with behaviors that are adaptive and appropriate. Time out and restraint are examples of restrictive procedures.

### **2. Prohibited Restraints /Practices of Behavior Control**

The Department of Children's Services prohibits non-hospital based Providers from using chemical restraints, mechanical restraints, and corporal punishment or peer discipline with youth enrolled in any program. The agency also is restricted from the use of key locks, slide bolts, or other such means of individual confinement. (In other words, the child cannot be locked behind a door for confinement.)

**Chemical restraint is:** a chemical substance for the control of problem behaviors which, when administered in a given dosage results in a decrease or the elimination of the individual's capability for self-preservation.

**Mechanical restraint is:** a mechanical device that restricts the movement of an individual or the movement or normal function of a portion of an individual's body.

### **3. Physical Restraint Guidelines**

The use of physical restraint is discouraged. The Provider is expected to intensively train staff in various techniques/manners of behavior management in order to successfully de-escalate behavior and avert the necessity for use of physical restraint in most situations. Any use of physical restraint must be reported as a TYPE A incident report.

**Physical restraint is:** any physical/body contact by staff to restrict the movement of an individual in order to control the individual's problem behavior.

- The use of physical restraint is limited to containment of behavior that clearly indicates the intent to inflict physical injury to self or others or to destroy property.
- A physical restraint should not be used until other de-escalating behavior management techniques have been attempted.
- Verbal direction and escort/guidance must be attempted prior to physical restraint when a child attempts to leave a group.
- Physical restraint shall only be used as a last resort to prevent behavior which may be harmful to the child being restrained or to others. It may only be used for the period of time required for the child to regain control of his/her behavior.

Physical restraint may only be used by staff properly trained by a certified trainer in a nationally recognized physical restraint technique. Examples of acceptable techniques are Cornell and Handle With Care. Policy takes precedence over any physical restraint technique when there is a conflict of terms. This training must be documented in the staff member's personnel file. At least two (2) staff members must be present and able to immediately participate in order to safely administer every physical restraint. Immediate notification to the supervisor on duty must accompany any physical restraint. An interview with the individual who was restrained should follow every physical restraint, structured to process the event. In the event, a youth incurs excessive restraints, the provider must develop an Individualized Crisis Management Plan involving all decision making participants of the youth's permanency plan. Each incident involving the use of physical restraint shall be reviewed in an agency administrative review process, with documentation of these reviews being available to the Department's licensing unit and contract monitoring staff. The review must include precipitating events, other events

attempted to de-escalate the behavior, use of authorized procedures, staff training issues, and any corrective action that may be required.

**Properly administered physical restraint controls the child safely. It cannot be used to retaliate, coerce, discipline or punish.**

The Provider must incorporate an internal review process of all restraints in their facility as mandated by DCS licensing standards.

## **K. DISCIPLINE POLICY/GRIEVANCE PROCESS**

### **1. Discipline Policy**

Each Provider must have on file and available for review a written policy regarding discipline for youth enrolled in the program, which at a minimum includes:

- A description of children's rights and grievance procedures
- A written list of rules that must be given to each child upon entry into the program
- A procedure for rewarding positive behavior
- A procedure for charging an offender with violation of a rule
- A procedure of constructive consequences for any violations of rules of the program
- An appeals procedure for the child to be able to use
- A commitment to guard the Due Process rights of children

Licensing standards require that "all discipline must be reasonable and responsibly related to the child's understanding, need, and level of behavior. All discipline shall be limited to the least restrictive appropriate method and administered by appropriately trained staff. Any discipline must be determined on an individual basis and be related to the undesirable behavior."

Such forms as the following types of punishment are prohibited under DCS Licensing standards: cruel and unusual punishment; assignment of excessive or inappropriate work; denial of meals, daily needs and program provided by the individual service plan; verbal abuse, ridicule or humiliation; denial of planned visits, telephone calls, or mail contacts with family; and, as previously addressed in J. 2., permitting a child to punish another child, and chemical or mechanical restraints.

### **2. Grievance Process**

The Provider must provide a posted procedure for a grievance process within the program. Residential Treatment Centers and Group Homes must offer a confidential locked container unavailable to direct care staff for each youth to submit any grievance. The Provider must have a posted review process of grievances and denote a specified time frame of each level of the process. Foster Care Agencies must have a grievance process in place for youth. Refer to **Appendix C**.

## **L. CLOTHING**

The Provider will assure that all children in the program have appropriate and sufficient clothing. The Provider is responsible for routine and ongoing clothing purchases after the child enters the program. Clothing purchases are included in the Providers per diem rate and are a requirement for each youth.

All children who enter State custody are eligible for an initial clothing allowance if the child's clothing is unavailable or inadequate. Additional clothing purchases may be approved if clothing is lost during moves from one placement to another. The DCS case manager is responsible for authorizing the purchase of clothing in these situations.

Clothing is the property of the child and moves with the child when the child leaves the program. Departmental representative must remove all clothing not removed prior to 30 days.

The Provider must supply any special clothing required for a child to participate in a certain program.

## **M. INCIDENTAL EXPENSES**

The Provider is responsible for program and normal age-related personal incidental costs for children in the program, such as bedding, camping equipment, diapers for infants, toiletries, personal hygiene items for females, etc. If these items are used as a basis for the child's participation and progress in the program, policy and client rules must reflect this, with a copy of these rules being on file in the facility and available for review.

*NOTE: The Department of Children's Services Administrative Policies and Procedures 20.8 concerning health services for females specifies that appropriate feminine hygiene items must be provided to female youth and be readily available, including sanitary napkins and tampons, and that minor females must be counseled by staff regarding risks of toxic shock syndrome (**must be documented in child's record**) involved in the use of tampons and must be allowed to choose between tampons and napkins.*

## **N. REFERRAL**

### **1. Children Served**

Only children referred by the Regional Resource Management Group (RRMG) who meet the criteria as specified in the definition of services of the DCS Provider Agreement will be served. As vacancies occur the Provider will accept all referrals, which meet the criteria outlined in the definition of services and this DCS Provider Policy Manual, based on a priority system established by the Department. Determinations regarding the order of admission are the discretion of Departmental staff.

### **2. Referral Packet Information**

Referrals will contain certain information and will be forwarded to the residential provider agency with an attached cover letter. The referral packet will be comprised of the following:

- Cover letter
- Social history (DCS social history and information sheet) with any addenda and revisions to include behavior and placement summary for the last six months
- Critical medical information; the needs of the child for any ongoing medical treatment; current prescription (and other) medications the child is taking
- Any “zero tolerance” issues that may exist
- Psychological assessment, if appropriate
- Permanency plan packet, including any revisions

The Permanency plan packet includes the permanency plan, attachment of Notice of Equal Access to Programs rights, attachment of Appeal Rights (for appeals within the region), and attachment of Notice of Termination Procedures. The new Notice of Action and the TennCare Medical Care Appeal Form should be attached.

- Agencies may admit emergency referrals, if appropriate for services without referral packets or with incomplete referral packets with information forwarded immediately as available by regional staff.

### **3. Time Limit to Accept Referral or Appeal; Appeal Procedure**

The Provider will within five (5) working days of receiving the referral packet determine whether the referral is appropriate or inappropriate and notify the RRMG. If the Provider determines that the referral is not appropriate and, after discussion, the referring RRMG maintains that the referral is appropriate, the Provider may appeal any referral viewed as inappropriate to his/her RRMG appeals committee within the same five (5) day period. The appeal must be in written form, including the name of the referred child, the RRMG seeking placement, and the specific characteristics of the child determined by the Provider to be beyond the scope of services as outlined in the Agreement. The Provider must send a copy of the referral packet to the RRMG appeals committee along with the written appeal.

Appeal procedures are to be carried out uniformly statewide utilizing standardized procedures, selection of members of the Grand Region Appeals Committee, service terms, election of chairperson, voting members, establishment of a quorum and meetings for the Appeals Committee, paperwork needed to make an appeal, Appeals Committee process and routing, and maintenance of statistical data concerning appeals. These appeal procedures, developed with the recommendation of the State Resource Managers and the TACC Appeals Committee, ensure a consistent procedure with fair representation. The process is organized and conducted as a Grand Region activity. A copy of the Appeals Procedures for Contract Placements follows in the manual, and may also be referenced in the Appendices to the manual (Appendix D).

The appeals committee will meet within 5 working days of receiving the appeal and is responsible for conducting a review and providing a written and final decision regarding the appropriateness of the referral. The Appeals Committee will make a decision on the appeal based on the information received from the Provider and in accordance with the Provider Policy Manual. The chairperson will notify all concerned parties by telephone following the

decision, and will follow up with a letter regarding the appeal decision within 24 hours to DCS, Provider and resource manager.

If a vacancy exists in the Provider's program at the time an appeal is made or being reviewed, the RRMG has the discretion to hold placement of any other referrals until the appeal is resolved.

The Provider will be responsible for any pre-admission visits to the child in the child's current placement.

#### **4. Maintenance of Waiting List for Placement**

The RRMG has the responsibility to maintain a waiting list for the Provider's program. Special classes of children/youths may be identified as priorities for waiting lists. The regional staff determines next admission for openings from the waiting list.

### **O. ADMISSION**

#### **1. Admission Provisions**

Admission can occur only when the Provider receives an **Authorization For Residential Placement form signed by the appropriate DCS regional resource manager**. The appropriate DCS staff member is responsible for the completion of any other necessary admission forms. The DCS case manager is responsible for transportation to and from the facility.

#### **2. Admission Packet**

The following information will be included in the packet:

- School records, including special education records
- Immunization records
- Court order(s)
- Birth certificate
- Social security card
- Insurance information---MCO/BHO identification numbers; if not available, a copy of the TennCare application is required

### **P. CASE RECORD**

The documentation of all service and treatment will be maintained in a child's case record. At a minimum a case record must contain:

- Authorization for Residential Placement form
- Child photo
- Information on the child's presenting problem(s)
- The anticipated length of stay
- Services provided to the child and/or family
- Incident reports

- Court Order(s), if available
- Educational information
- Social history
- Birth certificate
- Critical medical information including current prescriptions, need for ongoing medical treatment, etc.
- Psychological assessment/evaluation, if applicable
- Immunization record
- EPSDT screening and all follow-up
- Permanency Plan of Care
- Individual Program Plan/ Treatment Plan
- Quarterly IPP/Treatment Plan updates stating progress made and changes in treatment/services, estimated continued length of stay in the program
- Method for involving the family in the treatment process or permanency plan (or any restrictions on family and/or other contact)
- Documentation of all family and/or any other significant contacts
- Discharge plan
- De-Authorization of Residential Services form

If the above-cited required information is not in the record, the record must have documentation of the Provider's efforts to obtain/retrieve information. This documentation must be updated at least quarterly as long as the child is in the program.

#### **Q. INDIVIDUAL PROGRAM/ TREATMENT PLAN DEVELOPMENT AND IMPLEMENTATION**

The Provider must develop through an interdisciplinary team approach an Individualized Program Plan (IPP) or Treatment Plan, including a Family Involvement component, for each child. The initial IPP will be developed within thirty (30) days of admission, or as specifically stated for certain levels of care, and be consistent with the Permanency Plan developed for the child and family. The IPP/Treatment Plan will be developed by the Provider with input and approval of the DCS case manager. The DCS case manager will be invited to attend the IPP development staffing. The IPP interdisciplinary team will consist of all appropriate agency staff participating in the child's treatment, the child, the child's family if available, and the child's DCS case manager. All participating members will sign and date the document. The child and family will receive a copy of the completed IPP. If the DCS case manager is unable to attend the staffing, the Provider will present the IPP to the case manager promptly for review, input, and written approval. A copy of the IPP must be provided to the Home County Case Manager.

The IPP/Treatment Plan and service documentation should present a connected flow of information explaining the client's presenting treatment issues, a clear and complete plan to address those issues, documentation of the child's and family's progress within the context of the Plan, and will:

- be based on the Permanency Plan of Care, the assessment package, and behavioral observations

- include a statement of client behavioral and emotional treatment issues; clearly stated treatment objectives and goals; intervention strategies that are time-oriented, meaningful and measurable; and, identify responsible treatment personnel
- be modified in response to interventions or as new behaviors are targeted and be reviewed and updated/modified and approved at least quarterly. This review must follow the standard format for interdisciplinary treatment planning, must include any changes in the components of treatment for the child and family and clearly state the status of the current plan. All members of and participants in the treatment team must receive adequate notice of and be encouraged to attend such staffings. NOTE: All procedures must be carried out in compliance with the revised DCS Appeals Process.

The IPP will address the needs of the children and families served in the following areas:

- Permanency planning
- Client treatment issues and objectives
- Family reunification goals and objectives including visitation guidelines and family outreach objectives that are the responsibility of the Provider
- Age appropriate life skills/ independent living skills training
- Aftercare services, if available and appropriate
- Coordination and provision of services to family members or individuals included in the permanency plan

All treatment provided to a child is to be carried out in accordance with the child's IPP. All treatment provided to a child is to be documented in the case record, specifying the treatment provided, how the treatment relates to the goals of the child's treatment plan, and progress notes toward achievement of those goals.

Family involvement is an essential component in providing appropriate care and treatment for the child as well as empowering the family, which increases the likelihood of more timely and successful reunification. The IPP must address the goal of timely, successful family reunification along with measurable objectives to attain this for all youth with this goal. The Provider in cooperation with the DCS case manager will make reasonable effort to assure that the child and family have face-to-face contact at a minimum of once per month while in the program or as indicated in the Permanency Plan. The Provider must work closely with the DCS case manager to establish a visitation schedule. Passes must be in accordance with DCS Administrative Policies and Procedures 12.5 on this subject. Refer to a copy of this in Appendix A at the end of the manual. Documentation of the contact and/or efforts toward that goal must be documented in the child's case record. The Provider must ensure that unsupervised contact between the child and family occurs only as specified and approved in the IPP.

All releases, home placements and trial home visits must be in accordance with DCS Administrative Policies and Procedures. Refer to Appendix A for the following: Return to Home Placement: Youth Adjudicated Delinquent (12.1); Trial Home Visit/Termination of Custody: Youth Adjudicated Unruly (12.2); Release of Dependent and Neglected Children from State Custody (12.3); and Release from Custody of Dependent and Neglected Youth at Age Eighteen (12.4).

In cases where family reunification is not feasible, the DCS case manager must make that determination and an alternative permanency plan must be developed and approved by the Department.

The Provider will assist in the implementation of permanency plans. Permanency must be addressed for each child with each treatment plan.

## **R. MEDICAL/ DENTAL**

### **1. General Obligations of Provider**

The Provider must assure that any health services (physical, including dental, and mental) for children in the Provider's care are provided by a qualified professional. It is the responsibility of the Provider to arrange for the provision of the child's routine medical and dental health care. Additionally, the Provider will ensure that each child in the program is up to date on and receives EPSDT services as indicated in the periodicity schedule in Appendix B. The Provider in the child's records will document these screenings/evaluations. The child's private and TennCare insurance must always be used first for payment of these services.

The Provider will provide for clinical supervision of professionals conducting individual, group or family therapy. This supervision will be done individually or in small groups of two or three staff with the clinical director or professionally qualified supervisor.

The Provider will provide crisis intervention services for children available twenty-four (24) hours a day, seven (7) days a week including holidays. A crisis intervention plan will be operational and on file for review.

### **2. Emergencies**

The Provider must respond immediately to medical emergencies and contact the Department as soon as possible regarding the emergency. Medical emergencies that require a child to have E.R. treatment and/or hospitalization, or transfer to a mental health facility, are classified as Type A incidents and require reporting in the manner specified in the Incident Reporting Manual in Appendix C. The Provider is expected to transport the child to the source of emergency treatment whenever the condition of the child allows. If the child's condition is such that the Provider cannot safely transport, it is the Provider's responsibility to arrange for/obtain transport.

The Provider will provide crisis intervention services for children available twenty-four (24) hours a day, seven (7) days a week including holidays. A crisis intervention plan will be operational and on file for review. In the event, a youth has excessive medical, emotional, or behavioral issues, the Provider will develop and implement an Individual Crisis Management Plan for that youth.

### **3. Medication/Surgery Issues (including procedures for obtaining consent)**

#### **a. Storage of medication**

- Providers, including foster homes, will ensure that all medications including over the counter drugs are safeguarded by a double entry medication system

whereby each medication (name and quantity) is recorded as it comes into the agency.

- Administration of all medications must be documented, also. (This system is recording of the medication by name and quantity as it comes in to the agency and also upon each administration is the mechanism of “double entry”.)
- Medications must be double-locked. (Independent Living Programs involving ‘Apartment’ placement living may be granted waiver from this policy, if appropriate, and if not prohibited by such programs’ applicable licensing standards and any other DCS Policies.)
- All Prescription medications must be maintained in the original containers in all contract agencies.

In cases in which a child’s medical condition requires the child to have the responsibility and knowledge to self-administer a medication as an inherent part of the child’s treatment plan (such as insulin for a diabetic child); such administration should be by standing order from a licensed physician. (This is per licensing standards.) The Provider may then submit a copy of such standing order from the child’s physician as documentation for requesting and receiving acknowledgement from the Director of Residential Monitoring concerning this situation.

The Provider will appropriately store any medication requiring refrigeration or other special storage conditions.

#### **b. Psychotropic medication**

Psychotropic drugs must be individually prescribed and maintained in the original containers with the name of the physician, patient, drug, dosage, frequency and manner of administration, and prescription number unless filled directly by a physician. This includes all contract agencies. The Provider will document the requirement of the psychotropic medication in the child’s record.

The Provider shall use the most clinically appropriate and least intrusive intervention in treating children in the custody of DCS. Psychotropic medication shall not be used for the purpose of behavioral control or chemical restraint. [In the event of a psychiatric emergency, a one time dose of such medication may be used if the physician determines that the child’s safety is in jeopardy. The incident shall be reported to the case manager, the child’s parent (if appropriate), and the Regional Health Unit. A more detailed explanation follows in (1)(a). Prescriptions of such medications must be an integral part of the child’s treatment plan and congruent behavioral alternatives must have been tried prior to the use of such medications. All interventions must be well documented in the case record.

The Provider must assure that a licensed psychiatrist, preferably a child psychiatrist prescribes and monitors psychotropic medication and re-evaluates the mental health status of youth who receive such medication and/or who have a diagnosis of major mental illness. Every prescription of psychotropic medication must be accompanied by an explanation which includes the need related to the child’s

diagnosis, possible observed side effects, and other treatment alternatives already used or considered. The Department reserves the right to request a second opinion if there is reason to question the prescription of psychotropic medication.

**(1) Procedures for obtaining consent for psychotropic medication and/or surgery**

The Provider shall notify the home county case manager, in the case of a foster home, if a physician recommends psychotropic medication or surgery for a child. The physician shall document why the medication/procedure is needed, benefits to be derived, as well as possible side effects/risks of the medication/procedure.

The DCS home county case manager will then ensure, in the case of a foster home, that consent for the medication/procedure is obtained. A copy of the consent for psychotropic medication form that should be used by the DCS case manager to request consent may be found in Appendix B of this manual. Also in Appendix B is the form to be utilized in such occasions when parental/guardian consent will not be able to be quickly obtained and the consent must be obtained through the DCS Regional Health Unit R.N.

Informed consent occurs when the patient receives information about the drugs or surgery they will receive. Because minor children cannot give consent, someone else has to. When DCS takes a child into custody, DCS becomes the guardian. **When** parental rights have not been terminated, the State does defer to parents the right to provide that consent whenever possible. Sometimes the parent is not available; DCS gives consent in those circumstances. DCS requires that Providers tell DCS when a child is being given psychotropic **medications** or having surgery so that DCS knows of these situations. When consent is given, **it is not confirming that the child needs the medication**; it is stating that the individual providing consent has been informed of the benefits and risks.

Informed parental/legal guardian consent should be obtained if at all possible for children in physical custody of DCS. **When parental rights have been terminated or parents/guardians cannot be located**, the DCS Regional Health Unit Nurse or Nurse Practitioner must give consent. The following documentation must accompany any request for medication:

- the reason the medication is being prescribed
- the name of the medication
- the dosage prescribed and route of administration
- the expected benefits of medication
- possible side effects (The side effect profile of a medication may be handwritten or copied from a drug handbook or PDR. It is, however, vital that the copy, which may be faxed, is legible.)
- a copy of a legible prescription from the health care provider (physician, nurse practitioner, or physician's assistant)
- prescribing health care provider's name and telephone number
- any other medications the child is taking and any known medication allergies

The following documentation must accompany any request for a surgical procedure:

- a description of the surgical procedure
- reason the surgery is needed
- risk factors associated with the procedure
- post-surgical instructions, follow-up appointments, and any referrals that are to be made, such as physical therapy, home health care, etc.
- the surgeon's name and telephone number

**(a) Psychiatric emergency**

In the event of a psychiatric emergency when all other measures have been determined unlikely to prevent the youth from threatened harm as based on the professional judgment of a psychiatrist, a one time administration of psychotropic medication may be administered by a licensed health care provider without prior permission. The above-stated procedures to obtain consent should then be followed immediately. The same would be true for emergency surgical procedures. Documentation of the need for emergency administration of medication must be made in the youth's health record and must include the youth's specific behavior, what less restrictive alternatives were attempted and/or evaluated, and the reasons for ordering the medication based on the specific criteria of a psychiatric emergency. (Forms of psychotropics characterized by a slow rate of absorption and long duration of action, and antidepressants, must not be administered as emergency treatment.) In such **an emergency**, the Provider shall immediately notify the home county case manager, in the case of foster care, by phone of the **administration of emergency medication**. Written documentation of the emergency will be placed in the child's record and a copy forwarded to the DCS case manager within twenty-four (24) hours of the emergency. Area mobile crisis unit must be contacted for emergencies and services. The occurrence of such life threatening behavior as to necessitate this degree of intervention would constitute a Type A incident and all appropriate reporting must accompany this. Refer to Appendix C for a copy of the Incident Reporting Manual.

**(b) Admission of child already receiving psychotropic medication**

If a child is admitted to the Provider's program directly from the home of the child's parent or guardian and is already receiving prescribed psychotropic medication, notification of DCS and the child's parent/legal guardian relative to the need for the prescription, possible side effects, etc., is not required. However, the Provider must obtain written consent of the child's parent/legal guardian to continue administration of the medication. It is also the Provider's responsibility to assure that a licensed psychiatrist monitors the child in order to determine the need for continued administration of the medication and otherwise be responsible for ongoing evaluation and treatment of the child. In the event that an alternate or new psychotropic medication is prescribed, all previously described procedures apply.

If the Provider admits a child into a program who was placed on psychotropic medication while in the physical custody of another agency or program, the admitting facility will ascertain and document (through copies of relevant documents) that appropriate notification/authorization was obtained by the agency

where the child was residing at the time the medication was prescribed. **It is not necessary to obtain a new consent form.** However, if such verification cannot be established, the current Provider must carry out the appropriate notification/consent procedure. The previously mentioned necessity for psychiatric monitoring to determine the need for continued administration of the prescription and to otherwise provide ongoing evaluation and treatment **is also required** in this situation. Likewise, the necessary notification/consent procedure applies in the event that an alternate or new psychotropic medication is prescribed for the child.

*NOTE: A dosage change in a psychotropic medication that a child is currently receiving requires parental/legal guardian consent. A therapeutic range is acceptable for initial dosage or evaluation of medication.* Generally, a six-month period would allow sufficient time for evaluation of what dosage will achieve a therapeutic result, unless the child's psychiatrist otherwise indicates (that more time is necessary to reach therapeutic dosage).

#### **4. Medical Care Consent by Youth at Age 18**

Youth at age 18 must consent to their own medical care. Written consent must be obtained from the 18-year-old youth prior to administering medication and/or providing any other medical care. If a youth is unable to consent, the Department will make arrangements for a conservator.

### **S. ALLOWANCE**

#### **1. General Information**

The child's personal allowance is included in the per diem rate reimbursed by the State to the Provider. The Provider will set aside at **minimum** \$1.00 per day for each child in the program as the child's personal allowance. **The allowance follows the child and is the property of the child.** When a child is discharged from an agency, the contract agency should submit allowance funds in the total amount to the child's HCCM. HCCM should ensure that **the** child receives **the** money. In case of the death of a child, the money will be returned to the State. The allowance must be tracked with appropriate, auditable fiscal guidelines.

#### **2. Inappropriate Use of Allowance**

Allowance may not be used for normal age-appropriate hygiene items and/or clothing needs. It also may not be used for items that are an inherent part of the program inclusive of replacement of special clothing required by the provider. Examples of some of the items that the child's allowance should not be used for are diapers for infants, feminine hygiene items, standard haircuts, standard (as opposed to specific brand name) T-shirts, standard (as opposed to specific brand name) underwear, standard (as opposed to specific brand name) shoes, school field trips, breakfast cereal, mouthwash, cold medication, allergy relief medication, pain and fever relief medication, etc. Such expenses are the responsibility of the Provider.

Allowance may not be used to purchase/provide items that become the property of the facility. Children cannot be asked to pool their allowances to purchase recreational equipment or services within the facility (such as ping pong equipment, cable t.v, etc.).

**Property damage assessments due to poor supervision, related to youth's specific diagnosis, or otherwise due to facility oversight issues are not permitted.**

### **3. Appropriate Allowance Use**

The following are some examples of appropriate use of allowance:

- Tape players and/or CD players
- Tapes and/or compact discs
- Cameras
- Make-up
- Clothing of a particular name brand or type, which is beyond the routine clothing requirement
- Jewelry
- Gifts for family/friends

### **4. Methodology for Tracking Allowance**

The Provider must assure that the facility's accounting department is properly crediting the child's allowance to reflect the date of the child's enrollment into the program, as well as reflecting all debits and maintaining a running balance, in a manner that is available for review upon request.

The Provider will maintain a running log for each child, identified by the child's full name. There shall be a separate log for each child. Allowance credits should be initiated upon a child's entrance into the facility and monies should be available to the child in a timely fashion. Allowance debits (by amount) are to be recorded on the date of the transaction, with accompanying signature of the child or a witness in the event that the child is unable to sign for himself/herself. Any/all allowance debits (cash given to the child) by amount and date, documented by signature of youth, must be forwarded to and maintained by the facility's accounting department. The log will be available for review upon request and will follow (or a copy will follow) the child. Monthly printouts of balances will be available to staff as well as youth.

If at all possible a child should be allowed to manage their money and have access to pocket money.

When a child leaves the facility, a check request indicating the child's name, date of termination from the facility, the new placement (with full address), and the description "zero out allowance" will be forwarded to the accounting department. This will initiate a check for the allowance balance to follow the child to the next placement.

## **T. COMMUNICATION WITH THE DCS CASE MANAGER**

The Provider will, at a minimum, provide on a quarterly basis to the Home County Case Manager/DCS Resource Management Unit treatment summaries or progress reports for each child and family enrolled in the program. Such reports will include information regarding progress being made by the child and family in meeting-defined treatment objectives, any new problems or needs being evidenced by the child, recommendations for a revision of the child's Permanency Plan and/or Individual Program Plan if indicated, and an estimation of the child's continued length of stay in the program. DCS workers are required to have at least monthly face-to-face contact with youth.

Any staffing, Treatment Team, or Decision-Making team of a child must involve the DCS case manager, family and age appropriate children, and all involved adults indicated on the Permanency Plan and other appropriate parties, and all procedures must be carried out in compliance with the revised DCS Appeals Process.

## **U. COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT**

Under ADA, all contract facilities must reasonably accommodate children with disabilities in order to integrate them into the program to the extent feasible given each child's limitations, in order to make available equal access, equal services, and equal opportunities to such children. Refer to a copy of the Memorandum dated March 18, 1999, on the subject of ADA, in Appendix D at the back of the manual. Any question(s) about the facility's obligations related to ADA issues/concerns should be brought to the attention of the DCS Director of Resource Management.

## **V. TERMINATION OF AGENCY SERVICES**

### **1. Successful Program Completion**

Prior to successful completion of a program, the Provider will prepare a discharge packet and forward it to DCS **anticipating** the child's planned departure from the agency. There must be a discharge plan **staffing** held prior to release. The meeting **should** involve the HCCM, agency staff, all involved adults and the child (if age 12 or above).

NOTE: All procedures must be carried out in compliance with the revised DCS Appeals Process.

The discharge packet will consist of the following:

- Discharge summary - specifying why the request for discharge is being made, progress achieved by the child during the program placement, recommendations for continued treatment of the child and/or family, and a description of the child's current emotional and behavioral status
- Medical records - secured and/or prepared by the Provider following the child's enrollment in the **current** program
- School records - generated and/or obtained by the Provider and the case manager following the child's enrollment in the **current** program

- **A discharge staffing with all involved adults and age appropriate youth must be held and a transition plan developed for discharge**

## **2. Premature Discharge/Placement Disruption At Provider's Request**

*(See special requirements for Emergency Shelters and Primary Treatment Centers relating to this issue in "a." below.)*

When the Provider desires to discharge a child prior to successful completion of the program, the Provider must request a meeting with the home county case manager.

The meeting will occur within seven (7) calendar days of the date of the request. The purpose of the meeting is for the Provider and the DCS case manager to reach consensus on a plan of action that would either allow the child to remain in the program or move to a more appropriate placement. The regional resource manager must be notified of disruption proceedings. With the exception of very unique and unusual cases, DCS will not support removal of a child from the Provider's program with the recommendation to place the child in a program of comparable level and treatment components. If there is agreement, or **at** the decision of the appeals committee that the child needs to move to another placement, DCS will arrange for and move the child within fifteen (15) days following the date of the consensus decision.

If agreement/ consensus decision cannot be reached, the Provider may request an appeal with the RRMG appeals committee.

In compliance with the policy regarding appeals the request for an appeal should be made within a five (5) day working period from the date of the meeting with the DCS case manager, and should be in written form including the child's name, the specific characteristics of the child precipitating the request for premature discharge, and the Provider's recommendations for the child's placement. The appeals committee has the responsibility to make a final decision regarding the placement within five (5) working days of the date of receipt of the appeal.

In unusual circumstances when a child's behavior is so out of control as to make him/her a danger to self or others, the Provider may immediately remove the child from the program only with the approval from the DCS home county case manager.

The Provider should lend assistance to this process according to the plan of action that has been developed.

### **a. Request for removal of child from Emergency Shelters/Primary Treatment Centers**

Emergency Shelters and Primary Treatment Centers are required to give five (5) days notice prior to removal of a child from the facility (unless the child's behavior is such that it presents a danger to self or others).

NOTE: All procedures must be carried out in compliance with the revised DCS Appeals Process.

However, prior to such notice, a meeting/discussion with the home county case manager should have already taken place to discuss the basis for the request to remove the child. The purpose of such meeting is to come to a consensus on a plan of action. Unless the child's behavior does not fall within the scope of services as defined in the Agreement, a request to remove the child from the facility would not be appropriate. The regional resource manager must be notified of disruption proceedings. If an agreement cannot be reached, an appeal should be filed immediately.

**b. Repeat runaway situations**

In the case of runaway incidents, where the child appears to be a "repeat runaway risk", the Provider, DCS home county case manager, and Resource Manager should develop a safety plan for the youth, in compliance with the revised DCS Appeals Process, and reach a mutual decision on whether or not the child should remain in the program. Strong consideration should be given to the child's history of running away, safety concerns (for both the child and the community), need for additional supervision and/or need for a more secure facility placement.

If agreement cannot be reached and the Provider maintains that the child should not remain in the program, the Provider may appeal to the RRMG appeals committee for resolution. The child will return to and remain in the current placement pending outcome of the appeal. The procedure regarding the appeal process is as stated above. No child who has run away from a program may be denied readmission to the program at the sole decision of the Provider. If the child is to be removed from the facility, either due to mutual decision between the Provider and the DCS case manager or the decision of the appeals committee, the DCS home county case manager (or case manager) will remove the child as soon as possible but within fifteen (15) days of the decision.

**c. Criminal acts by children while in placement**

Charges may not be filed against a youth by a Provider for behaviors that may be symptomatic of the youth's mental health diagnosis and/or treatment needs. The Provider should discuss the situation with the case manager and Resource Manager and mutually determine whether or not continued placement is appropriate, given the child's history, the incident itself, the risk to others in the program, the possible need for additional supervision and/or a more secure placement, etc. If agreement cannot be reached and the Provider maintains that the child should not remain in the program, the Provider may appeal to the RRMG appeals committee, file a TennCare appeal, or request a review by the Regional Administrator and/or Central Office Resource Development, in the manner previously described above. The child will remain in the current placement until a decision is made. If the decision is to remove the child from the program, DCS will remove the child as soon as possible but within fifteen (15) days from the date of the decision. **All procedures must be carried out in compliance with the revised DCS Appeals Process.**

**3. De-Authorization of Services**

De-authorization may occur when it is determined that appropriate services to the child are not being provided and/or services are no longer needed from the Provider. In this case, the resource manager gives notice to the Provider and a discharge staffing with all involved and appropriate individuals must be set, not later than thirty (30) days from notice. De-authorization should be a consensual decision between Provider, home county case manager, resource manager (RM), the child, family case manager and all involved adults. After care needs **should be** addressed. If the Provider (or the child and family case manager) feels that continued stay is warranted, additional information may be submitted to the resource manager to justify this. The resource manager will make a decision within five (5) days of receipt of the additional information, and if the RM still feels that de-authorization is appropriate, any involved party may request an appeal. The procedure for the appeal is as described previously. If consensus cannot be obtained, providers may appeal to the RRMG and the Regional Administrator. **If there is a clinical disagreement, a referral should be sent to one of the following, as agreed upon in the staffing, for resolution:**

- **Review by Regional Psychologist and/or nurse as specific situation indicates is most appropriate**
- **Review by DCS Director of Medical and Behavioral Services**
- **Review/Consultation through the Center for Excellence**
- **Any involved party has the right to file a TennCare Appeal.**

## **W. SUPERVISION OF CONTRACT AGENCIES**

1. All contract agencies which provide placements or services to children in the Brian A. plaintiff class shall only do so pursuant to annual performance-based contracts issued by DCS.
2. DCS shall only contract with those agencies that meet the provisions of this Settlement Agreement that specifically apply to those agencies and that meet state standards governing the operation of child care facilities. These state standards shall reflect reasonable professional standards. DCS shall not contract with any agency that has not been licensed by the State to provide placements for children in the plaintiff class.
3. All contract agencies providing placements for children in the Brian A. plaintiff class shall be inspected annually by DCS licensing staff in an unannounced visit. DCS shall determine in a written report whether the agency complies with state licensing standards. The licensing unit shall collaborate with the DCS quality assurance unit and the central office resource management unit to determine agency compliance with the terms of this Settlement Agreement.
4. Alleged abuse or neglect of children placed with a contract agency must be reported by the agency to the DCS child protective services unit in the county in which the facility is located. Additionally, alleged abuse or neglect concerning children placed with any contract agency shall be reported to the central office resource management unit and the quality assurance unit. DCS shall incorporate these reports and their findings into the annual review of each contract agency. DCS will evaluate carefully those reports and

consider prior corrective actions, the history of the agency and determine if there are serious problems that place children at serious risk of harm and prevent further contracts from being issued.

In the event that the Residential Continuum Monitoring Unit determines that a contract agency has significant deficiencies that require prompt corrective action(s), Residential Continuum Monitoring will make the facility aware of all problem areas and request a corrective action plan. The facility is expected to provide a plan to correct the noted deficiencies. Upon receiving the corrective action plan Residential Continuum Monitoring will re-evaluate the status of the facility.

If Departmental staff concludes that adequate improvement has not occurred by the end of the notice period, the agency will be made aware of the ongoing noted problems, and the agency will be bought before the Network Performance Committee committee. The facility is expected to provide a detailed plan of corrective action to produce prompt compliance.

At any time that an incident/situation of such serious proportion occurs that indicates there are questions regarding the agency's ability to safely care for the children in our custody, a facility may be immediately placed on probation and have admissions suspended until such time as a full investigation may be conducted to determine the safety of the facility. Serious safety issues or contract compliance issues may result in immediate cancellation of contractual relationship and ineligibility for future contracts or subcontracts for services to the State.

## **X. PAYMENT FOR SERVICES**

### **1. Daily Per Diem Rates for Contracted Agencies 2003-2004**

<b>Level of Service</b>	<b>Rate</b>
Detention	132.38
Primary Treatment Center	153.67
Emergency Shelter	50.32
Foster Care	48.70
Medically Fragile Foster Care	99.45
Foster Care Therapeutic	94.71
Level 1	50.04
Mom-Baby / Maternity	50.04
Level 1 Independent Living	50.04
Level 2 Special Population	108.38
Level 2 Special Population Wilderness	108.38
Level 2	98.26
Level 2 Special Needs	110.45
Level 2 Continuum	84.85
Level 3	192.44

Level 3 Continuum	145.45
Level 3 Continuum Special Needs	156.43
Level 4	312.00
Level 4 Special Needs	442.68
Education (250 days in a calendar year; example: 250 x slots x 41.77 = maximum liability)	41.77

## **2. Days of Paid Service**

The Provider will be paid for the day (date) the child enters the program but not the day (date) the child is terminated from the program. Day (date) is defined as any part of a twenty-four (24) hour period from midnight until 11:59 p.m. For each child/youth served, the Provider will multiply the service unit rate by the number of days that the child/youth is in the Provider's facility/program. Providers will bill on DCS Form 12, and should indicate if they are billing for days the child is on approved leave from the program. Claim forms must be typed in order to ensure legibility of the data. The name and identifying information on the claims form must exactly match the information on the authorization for residential services form.

## **3. Client Days**

Client days are calculated by multiplying the number of slots by the number of days of service. Billing must follow DCS Form 12 billing and approval process.

## **4. Hospitalization**

The Provider may be reimbursed for days a child is hospitalized for up to seven (7) days if the Provider plans to take the child back into the program. After seven (7) days and up to twenty-one (21) days, the Provider may be reimbursed if written approval is obtained from the Regional Administrator (R.A.) or designee to hold the Provider's slot open. **The Region will need to use flex funds to have a residential program staff sit with a youth who is in a hospital 24-hours a day apart from the facility.**

## **5. Leave/Transition**

A child may have approved leave from a program for up to fifteen (15) days during which period of time the Provider may be reimbursed. Such leave may include visiting family or going to summer camp. Approved leave must be in writing from the Regional Administrator (or designee), and does not include the time a program may be closed for a weekend or holiday. The Provider must be open and available to provide services during this period of time in order to receive compensation. The Regional Administrator (R.A.) or designee will base compensation on a case-by-case approval.

## **6. Runaways**

The Provider may be reimbursed for runaways for up to ten (10) days after a child has run away if the Provider is holding the bed for the child and is willing for the child to return to the program, with authorization from Regional Resource Management staff.

## **7. Detention During A Program Placement**

When a youth enrolled in a program is placed in detention for the commission of an act, the Provider may be reimbursed for up to seven (7) days, if the Provider is holding the bed for the child to return to the program and has notified the Regional Administrator (or designee) of that intent and the R.A. is in agreement. The Regional Administrator may reimburse any additional days only with permission and justification in writing. **No youth may be placed in detention unless the youth meets the specific scope of services for detention and is appropriate under Tennessee Code Annotated.** A child placed in the physical or legal custody of the Department of Children's Services with an adjudication of dependent/neglect or unruly shall not be placed, in a jail, correctional facility or detention center unless a child has been charged with a detainable delinquent offense or unless otherwise placed or ordered by court. (See Policy 16.49 Appendix E).

## **8. Moves**

The Department of Children's Services Home County Case Manager must be advised of any move of children and youth with information about the move and location. Permission must be given in advance by the HCCM for any move. In emergency cases the HCCM must be notified immediately or next working day and permission **must be** obtained. The Department must be notified of the exact address, telephone number and contact person for any location where a child resides.

## **9. Respite**

Respite is a temporary break in care, with the expectation that the child will return to the original placement location. Any other location change is considered a move and must be reported and documented as such.

## **10. Independent Living**

All children should have age and developmentally appropriate self-sufficiency and independent living activities, goals and services incorporated into their treatment plan.

# **Y. CONTRACT PERFORMANCE MEASURES**

The Contractor shall provide information for performance reviews in the following categories, as requested by the Department of Children's Services:

## **1. Child Safety**

- a.** Number and type of founded Child Protective Services reports
- b.** Number and type of child injury incidents

- *Child Injury*

- Type A Child Injury includes: assault (major), excessive force, CPS death or serious injury, emergency treatment, and self-mutilation. All of these include child injury as part of their definition, and all of these categories are classified as Type A. Other incident categories (such as restraint) may involve injury as well. Type A Incident Report of Child Injury: any injury requiring any medical attention.

- c.** Number of runaway incidents

- *Runaway*

Definition of Type A Incident Report Runaway: A youth leaves without authority and does not return within four (4) hours. A child is under the age of 12 and a child/youth with mental or physical issues which, without supervision may pose a child safety or community safety risk, is reported immediately as Type A.

## **2. Movement**

- a. Identifying information on each youth who moves from one location to another location of any type during the month. A move is any change in placement location except for temporary breaks in service due to temporary hospitalization, runaway with return, and respite. A change in location includes moves from foster home to foster home or from cottage to cottage as well as change in program.
- b. Reason for each move
- c. Information regarding move location(s)
  - There are three types of moves: Planned, Unplanned, and lateral. A Planned move is a move which occurs as a result of a staffing, in advance, with all involved adults and age-appropriate children. As a result of the meeting, consensus is achieved regarding the move being in the best interest of the child. A permanency staffing form or other staffing form is signed by all, documenting the meeting. An Unplanned move is a move which occurs without a staffing, in advance of the move, with all involved adults and age appropriate children regarding the move being in the best interest of the child. A lateral move is from one foster home to another, one cottage to another, or one program to another within the same level of care.

## **3. Permanency/Successful Program Completion**

- a. Identifying information on youth leaving program to permanency placement, with discharge placement and type
  - Noncontinuum program successful program completion/discharge: Youth left the contract successfully completing the program treatment plan.
  - Continuum Successful Completion/discharge: Youth left the program to the permanency goal placement as outlined in the permanency plan (adoption, reunification, planned permanent living arrangement, etc.)
  - Unsuccessful noncontinuum program completion: Youth left the program without successfully completing the program treatment plan. Youth ran away and did not return, youth went to a hospital or detention center and did not return to the contract agency. This also includes youth who went to other programs/contracts without successfully completing this program/contract due to disruption.
  - Unsuccessful continuum program completion: Youth left the program without achieving permanency as outlined in the permanency plan. Youth ran away and did not return, youth who went to a hospital or detention center and did not return to the contract agency. This also includes youth who went to other programs/contracts without successfully completing this program/contract due to disruption.

- b. Length of stay in contract all youth discharged by discharge placement
- c. Length of stay in contract for all youth remaining in the program
- d. Re-entry to custody of youth completing program

**4. Family Involvement**

- a. Number of face to face contact between custodial youth and siblings
- b. Number of face to face contacts with parent(s) or adults identified as potential permanency placement on permanency plan
- c. Number of child and family involvement in service planning

**5. Reporting and Compliance**

- a. Agency will have current required license for services provided
- b. Agency will comply with submission of required reports, site visits, and data requests in a timely and accurate manner

Agencies will be evaluated on ongoing basis in regard to the above factors, with at least an annual review of compliance, service history, and performance in at least a minimum of the areas listed above.

**Z. Contract Management**

Each contract has an allocation, a number of annual bed days, for a region or regions. It is the responsibility of the Contract provider to have a tracking mechanism for the regional allocation(s) that monitors the utilization of the contract by region(s). Bed days are an annual allocation that can be divided by 365, giving an average daily census. Contractors may, at times, run slightly under or over the allocations, as it equates to an average census. If a region's usage exceeds the allocation, the contract vendor and regional resource staff must meet to resolve the issue, or request, in advance, an amendment to the existing contract.

## **II. EMERGENCY SHELTERS**

### **A. PROGRAM DESCRIPTION**

Emergency Shelter programs provide immediate placement to youth initially entering custody of the Department of Children's Services (DCS), or youth with emergency disruptions who need short term care. The service must not exceed thirty (30) days in duration. Emergency Shelter programs work to stabilize youth before they are moved to a permanent placement. Youth must either attend a Department of Education (DOE) and DCS approved in-house school or the local community school.

### **B. POPULATION SERVED**

Children may be dependent/neglected, delinquent, unruly or abused. Children may display chronic runaway behavior, manipulative behaviors, difficulty maintaining self-control, poor self esteem, difficulty in securing and maintaining close relationships with others, habitual truancy from school and/or have difficulty in accepting authority. Children do not pose a safety risk to the community or other children.

Youth who meet the following criteria are ineligible for Emergency Shelter services:

- Youth who have been found to be delinquent, or are alleged to be delinquent, based upon a felony offense constituting a crime against a person or persons
- Youth who have prior commitments to DCS as a result of having committed a felony offense or offenses which constitute a crime against a person or persons
- Youth who are found to be delinquent, or are alleged to be delinquent, based upon a felony drug offense
- Youth who have prior commitments to DCS as a result of having committed a felony drug offense
- Youth who have a history of prior convictions for felony offenses, which constitute crime(s) against persons, or felony drug offenses, even though the youth has never been committed to DCS.

Delinquent youth meeting the above criteria may be housed in an emergency shelter with youth who have been adjudicated dependent/neglect ONLY IF:

- There is total separation between facility spatial areas such that there could be no haphazard or accidental contact between a child alleged to be delinquent, or committed as a delinquent and a child alleged to be dependent or neglected
- There is total separation in all program activities between children alleged to be delinquent, or committed as a delinquent and children alleged to be dependent or neglected.

Youth who are delinquent, but do not fall into the criteria above, may be housed in a shelter with dependent/neglected youth if the youth otherwise meets the scope of services for an emergency shelter.

**C. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Room and Board
- Counseling Services/Crisis Stabilization
- School liaison
- Social Services/Case Management and Coordination

**D. STAFFING PATTERNS**

- Ages 5 and up, 1:8 ratio; staff are not required to be awake at night
- Age 0-4, 1:6 ratio; staff are not required to be awake at night

**E. REFERRAL/ADMISSION**

Only children referred by the Regional Resource Management Group (RRMG), or other entity approved by the State, who meet the criteria as specified in the definitions of services of the Provider Agreement shall be served through this Agreement. Admission can only occur when the Provider receives an “***Authorization for Residential Placement***” form signed by the appropriate ***DCS regional resource manager***. The Department of Children’s Services shall be responsible for transportation arrangements to and from the facility. As vacancies occur, the Provider shall accept all referrals that meet the criteria outlined in the definition of services and this Provider Policy Manual based on a priority system established by the Department of Children’s Services. Providers must indicate approval or denial of the requested admission within three (3) hours after the referral is made.

If the Provider denies the referral, the Provider must provide a clear explanation to the RRMG as to why the child is considered to not fall within the scope of the population to be served. If the RRMG does not concur and maintains that the child is an appropriate referral, an appeal should be filed immediately.

The Department of Children’s Services shall verbally notify the Provider of the following:

- The child’s commitment status (e.g. dependent/neglect, abused, unruly, delinquent)
- The county from which the child was committed and the date of the commitment
- The circumstances surrounding the child’s commitment
- Current and past behavioral patterns (including history of child’s prior appearances in juvenile court and referrals or commitments)
- Any known medical conditions, including current medications and need for ongoing medical treatment
- Information regarding current medical/dental insurance
- Emergency contact numbers for the DCS case manager and the child’s parent(s) or guardians

Emergency Shelters will typically serve children initially coming into the custody of DCS; therefore, only minimal records regarding the child and family may be available at the time of the requested admission. At a minimum, DCS shall make available to the Provider, as soon as possible, a copy of the child's commitment order in addition to verbal information specified above. As additional documents become available, they shall be shared with the Provider. Such documents include the following:

- Social History (DCS social history and information sheet)
- School Records
- Immunization Records
- Psychological Assessments (if available or applicable)
- Permanency Plan of Care
- Birth Certificate
- Social Security Card

#### **F. CASE RECORD**

The Provider shall maintain a case record on each child enrolled in the program that includes the following information:

- All verbal and written information provided by DCS regarding the child and family
- Copies of all correspondence with DCS regarding the child and family
- Documentation of the child's adjustment in the program, including reports of interactions with peers, interaction with those in positions of authority, any observed emotional or behavioral patterns, and reports of any disciplinary infractions or offenses
- Education records generated or obtained by the Provider
- Medical records generated or obtained by the Provider
- Case recordings and all other documentation concerning contacts or developments in the cases of class members shall be added to the case file for that child within 30 days of the case work activity or development. The case files of class members shall contain adequate documentation tracking the services provided, progress, any change in placement of the child, and authorizations which document the approval for placements, treatment and services provided to each child.
- No child may remain in any shelter program for over thirty (30) days.

#### **G. TREATMENT PLAN DEVELOPMENT**

The Provider shall document and cooperate with DCS in providing for the immediate treatment needs of any child enrolled in the program. Service components that are not a required part of the per diem rate paid to the Provider are the responsibility of the State. The State, in cooperation with the Provider, shall utilize TennCare to address immediate service needs.

## **H. DISRUPTION NOTICE**

Emergency Shelters shall give five (5) calendar days notice prior to the removal of any child from the facility. **All procedures must be carried out in compliance with the revised DCS Appeal Process.** However, prior to such notice the Provider will have already met with the DCS home county case manager to discuss the basis for the request to remove the child. The purpose of such meeting is to come to a consensus on a plan of action for the child. Unless the child's behavior clearly is beyond the scope of the required population to be served, a request to remove the child from the facility would not be appropriate. The regional resource manager must be notified and an appeal should be filed immediately.

In unusual circumstances when a child's behavior is so out of control as to make him or her a danger to self or others, the Provider may immediately remove the child from the facility only with approval from the DCS case manager.

### **III. PRIMARY TREATMENT CENTER**

#### **A. PROGRAM DESCRIPTION**

Children referred to Primary Treatment Centers may be children in their initial **commitment to state custody**, children already in state custody, and children who have been released from state custody and have been recommitted. These children display a wide range of behaviors and will be served in a Primary Treatment Center according to their individual needs.

#### **B. POPULATION SERVED**

Children may have Level II or III substance abuse needs. Children may have delinquent charges, display chronic runaway behavior, display manipulative behaviors, have difficulty maintaining self-control, display poor self esteem, have difficulty in securing and maintaining close relationships with others, be habitually truant from school and have difficulty in accepting authority. Children appropriately referred to a Primary Treatment Center do not pose a significant risk to community safety.

Primary Treatment Centers shall provide the following services within the per diem rate:

- comprehensive and uniform assessments and evaluation
- individual and family treatment upon admission
- length of assessment limited to no more than 15 days with immediate provision of treatment as identified in the Permanency Plan with written report to the Department of Children's Services (DCS) within 20 days
- Coordinate with families and DCS staff as appropriate
- Home-based services designed to observe, treat and assess families who can successfully and safely be provided these services within the home and community
- Emergency care services for children returning from run-away status or in a status requiring re-assessment of the appropriate level of treatment service, or direct referral to placement
- Flexible methods to complete assessment and treatment for children who exhibit behavioral, emotional or social problems that prevent in-home assessment or who, due to the nature of the petition for removal, do not have family members to provide appropriate in-home care
- Assessment centers to provide observation, assessment and treatment in a group setting for children who cannot remain at home and who are inappropriate for, or disrupt from, a foster family placement during the evaluation service. Twenty-four hour (24) awake staff is required with a 1:8 ratio at all times
- Treatment for children with significant alcohol and drug issues and behavioral/mental health needs. Twenty-four (24) awake staff, with 1:5 ratio during awake hours and 1:8 ratio at night
- Coordination of services indicated in Early Prevention, Screening, Diagnosis, and Treatment (EPSD&T) evaluation

- Completion and coordination of all comprehensive psychological, psychosocial, psychiatric (medication and medication review), psychosexual, educational, vocational, and all other necessary evaluations as detailed below.
- **Children shall not remain in emergency or temporary facilities, including but not limited to emergency shelters, for more than 30 days. Children shall not be placed in more than one shelter or other emergency or temporary facility within any 12 month period. An exception to the multiple placement limit within any 12-month period may occur for an individual placement episode for a maximum of 5 days. The exception shall only apply to runaways and children facing a direct threat to their safety, or who are a threat to the safety of others, where immediate removal is necessary. As an additional exception to the multiple placement limit within any 12-month period, if a child's behavior has changed so significantly that placement for the purposes of assessment is critical for the determination of an appropriate placement, and the regional administrator certifies in writing that the assessment is essential for an appropriate placement, there may be a single additional placement in a primary treatment center (PTC) for up to a maximum of 15 days.**

### C. ASSESSMENT AND EVALUATION RESPONSIBILITIES

Guidelines for Completion of Psychological Screenings and Evaluations of Children in Custody

Psychological screenings shall be administered for all children in the custody of DCS who enter the Primary Treatment Center and shall, at a minimum, consist of at least the following instruments or procedures:

- A clinical interview (conducted by a licensed clinical psychologist, or conducted by a licensed psychological examiner and/or psychological examiner intern who is directly supervised by a licensed psychologist)
- A review and evaluation of available social history and behavioral health information.

Partial psychological evaluations (i.e., specific tests or measurements) shall be conducted when a child:

- Demonstrates the need for a specific test to identify or clarify dysfunctional maladaptive behavior and/or symptoms
- Demonstrates the need for a more intensive evaluation than a screening for development of an individual treatment plan and identification of service needs
- Demonstrates the need for an evaluation as identified on the EPSD&T
- Requires administration of one or more specialized assessments necessary for completion of an education or mental health diagnosis (e.g. adaptive behavior assessments necessary to determine if a child is mentally retarded).

A partial psychological evaluation should consist of at least the following instruments or procedures:

- A clinical interview (conducted by a licensed psychological examiner, licensed clinical psychologist, or psychological examiner intern who is directly supervised by a licensed psychologist)
- Any assessment necessary to complete the referral question made by a DCS case manager or identified by the examiner for further inquiry.

Partial psychological evaluations may include the following measures:

- Neuropsychological assessment measures
- Chemical abuse/dependency assessment measures
- Speech and language measures (e.g. articulation, expressive, receptive speech, and/or language processing deficits)
- Psychosexual evaluations
- Vocational interest or ability assessments
- Tests of achievement, adaptive functioning, or cognitive abilities.

A child shall receive a full psychological evaluation if he has not received one in the past three years **and** meets at least one of the following conditions:

- Child demonstrates the need for more intensive evaluation at the time of the psychological screening
- Child demonstrates the need for more intensive evaluation based on medical necessity or for development of an individual treatment plan for intensive treatment needs
- Child demonstrates the need for more intensive evaluation as identified on the EPSD&T screening.

A full psychological evaluation shall, at a minimum consist of the following components:

- A clinical interview, review and evaluation of all available social history and behavioral health information
- An individually administered test of intelligence
- An objective personality measure
- A projective personality measure
- A measure of academic achievement which assesses basic reading comprehension, mathematics calculation, mathematics reasoning, and written expression.

All five (5) Diagnostic and Statistical Manual, Fourth Edition DSM-IV) axes shall be addressed in full evaluations. The resultant reports should note the following:

- DSM-IV diagnoses, axes and codes
- Where diagnostic uncertainty exists on Axes I and II (V code, deferred, provisional, etc.)
- When no DSM-IV diagnosis is offered and/or when an axis does not apply.

The Evaluation Report should address the possible presence of an educational disability by:

- Noting a child's existing educational disabilities along with the school system making the determination and the date of the eligibility determination
- Noting that the criteria for an educational disability have been met in the current evaluation according to the Special Education Manual and Tennessee Administration Policies and Procedures Manual of the Department of Education. A recommendation should be in the report which states that a school assessment team should review and consider the child for special education
- Noting that an educational disability is suspected although criteria have not been met, referring the child for a school assessment team follow up and completing a comprehensive evaluation to determine if the child meets criteria for special education services, or
- Noting that there is no evidence of an educational disability.

The following convention shall be observed in reporting test scores for disability determinations by a multi-disciplinary team (M-team):

- Composite scores and subtest scores where relevant must be reported on I.Q. tests along with the standard errors of measurement for each score (e.g., Wechsler Intelligence Scale for Children, Verbal I.Q., Performance I.Q., Full Scale I.Q. and standard errors of measurement for each)
- The examiner must note the confidence level he or she has observed
- Standard scores and percentile scores must be reported on all achievement tests (other derived scores to be reported at the examiner's discretion)
- Percentile scores and, where possible, standard scores must be reported on all adaptive behavior measures and developmental scales (other derived scores to be reported at the examiner's discretion).

Report recommendations should address any referral questions presented by DCS staff and should note what additional testing or information is necessary to answer the referral questions.

#### **D. TREATMENT PLAN DEVELOPMENT**

The DCS Provider shall develop a treatment plan within fifteen (15) days. The DCS provider must document and provide treatment or coordinate treatment for any identified or indicated need of any child enrolled in the program. The DCS provider, in cooperation with DCS shall utilize TennCare to address immediate medically necessary service needs.

#### **E. REFERRAL AND ADMISSION COMPONENTS**

Admission can only occur when the Provider receives an "Authorization for Residential Placement" form signed by the appropriate DCS regional resource manager. Providers must indicate approval or denial of the requested admission within three (3) hours after the referral is made.

If the Provider denies the referral, a clear explanation must be given to the RRMG as to why the child is considered to not fall within the required population to be served. If the RRMG does not concur and maintains that the referral is appropriate, an appeal should be immediately filed.

The Center will typically serve children initially coming into the custody of DCS; therefore, only minimal records regarding the child and family may be available at the time of the requested admission. At a minimum, DCS shall make available to the Provider, as soon as possible, a copy of the child's commitment order in addition to verbal information to include:

- The child's commitment status (dependent/neglect, abused, unruly, or delinquent, with specifics regarding the delinquent charges)
- The county from which the child was committed and the date of the commitment
- The circumstances surrounding the child's commitment
- Current and past behavioral patterns (including history of child's prior appearances in juvenile court and referrals or commitments)
- Any known medical conditions, including current medications and need for ongoing medical treatment
- Medication consent form for all psychotropic medications
- Information regarding current medical/dental insurance (copy of TennCare card or application)
- Emergency contact numbers for the DCS case manager.

For children already in custody, the following shall be made available to the Center by day 3:

- Current Social History (up to date)
- School Records, including special education status, if applicable
- Immunization Records
- Copies of prior mental health and in-home/family related services records, including psychological assessments (if available or applicable)
- Current Permanency Plan of Care (up to date)
- Birth Certificate
- Social Security Card
- Medication Consent Form for all psychotropic medications (if not available on the day of admission)
- All documents not available at the time of admission
- Identification of all areas that need to be addressed through the evaluation process.

For children coming into custody for the first time and for whom the above documents are not immediately available, DCS will provide them to the Center as quickly as obtained and, in all cases, by day 10 of admission to the Center.

## **F. ASSESSMENT ACTIVITIES**

The Center shall ensure provision of assessment activities according to the assessment protocols as well as other areas identified by the Center staff or DCS staff. Assessment activities will minimally include:

- Review of the DCS referral form and discussion with DCS to determinate the most appropriate level and location of service
- Review of existing data
- Establishment of a timeline for the specific areas to be addressed prior to staffing;
- Assessment as to the appropriate level in the areas of:
  - Education
  - Behavioral health
  - Substance abuse
  - Independent living skills (age 15+)
  - Resource assessments to include family and community resources
  - Milieu evaluation for center-based service
  - Treatment recommendations
  - Placement recommendations
  - Testing/evaluations needed for each child.

The Center will provide a comprehensive assessment/evaluation report.

## **G. TREATMENT ACTIVITIES**

The Center shall ensure provision of treatment activities to include:

- Orientation to the child and family regarding the Center services and structure according to the level of service to be provided to the child and family. If the child is to be served at home, the Center must provide 24-hour availability 7 days per week. If the child is to be served in a group setting, the orientation must include house rules and the provision of adjustment groups.
- Preliminary treatment plan by day 2
- Family therapy
- Individual and group therapy
- Parent support group
- Parent-child activities
- Child support group
- Case management
- Therapeutic milieu
- Family therapy
- Milieu participation for center-based services
- Therapeutic home visits
- Educational programming: The Center will ensure the provision of educational programming, beginning at admission. The Center has the option of ensuring the child is enrolled in their LEA, another LEA or in a DOE-approved education program, meeting all educational requirements, including special education.

- Transportation:
  - Routine transportation within 60 miles (one way) of the program
  - Emergency treatment transportation
  - Assistance with providing and coordinating family travel
  - Assistance with providing and coordinating family, child and youth travel, if the service is home-based or foster family-based
- Flexible visitation schedules
- Access to all TennCare services for which the child is medically eligible, including EPSD&T medical screening (interperiodic required for all new commitments) and EPSD&T dental services according to the EPSD&T periodicity schedule
- Initiation of formal treatment following development of the Permanency Plan, if not begun prior to the development of the Plan
- Provision of transition services
- Assurance and coordination of transition to placement, within or outside of agency services.

## **H. CASE RECORD**

The Provider shall maintain a case record on each child enrolled in the program that includes the following information:

- All verbal and written information provided by DCS regarding the child and family
- Copies of all correspondence with DCS regarding the child and family
- Documentation of the child's adjustment in the program, including reports of interactions with peers, interaction with those in positions of authority, any observed emotional or behavioral patterns, and reports of any disciplinary infractions or offenses
- Education records generated or obtained by the Provider
- Medical and all assessment and treatment records generated or obtained by the Provider
- Case recordings and all other documentation concerning contacts or developments in the cases of class members shall be added to the case file for that child within 30 days of the case work activity or development. The case files of class members shall contain adequate documentation tracking the services provided, progress, any change in placement of the child, and authorizations which document the approval for placements, treatment and services provided to each child

Daily progress notes are required in the case record of each child. These notes should be based on progress in meeting assessment and treatment goals, and should include all information concerning any incidents, home passes, family visitations and interactions, and/or any new needs evidenced by the child and/or family. Documentation of milieu treatment must be included in the client file.

## **I. DISRUPTION NOTICE**

**Primary Treatment Centers** shall give five (5) calendar days notice prior to the removal of any child from the facility. **All procedures must be carried out in compliance with the revised DCS Appeals Process.** However, a meeting with the DCS home county case manager should have already taken place prior to such notice, to provide the home county case manager with the basis for the request for removal of the child and to come to a consensus as to a plan of action for the child. Unless the child's behavior is clearly beyond the Provider's required population to be served, such a request would not be appropriate. If agreement cannot be reached with the DCS home county case manager as to a plan of action for the child, the regional resource manager must be notified and an appeal filed immediately.

In unusual circumstances when a child's behavior is so out of control as to make him or her a danger to self or others, the Provider may immediately remove the child from the facility only with approval from the DCS case manager.

## **IV. DETENTION CENTERS**

### **A. PROGRAM DESCRIPTION**

Detention Centers are secured, locked facilities designed for youth who pose a risk to the community due to delinquent behaviors and charges, as outlined in Tennessee Code Annotated (T.C.A ) 37-1-114.

### **B. POPULATION SERVED**

Male/female children from ages 12-18, according to T.C.A. 37-1-114.

Eligible Children: An eligible child may be detained in a detention facility if any of the following apply:

- The child has committed a delinquent offense constituting a crime against a person resulting in the serious injury or death of the victim or involving the likelihood of serious injury or death to such victim
- The child has committed any other delinquent offense involving the likelihood of serious physical injury or death, or a property offense constituting a felony, and the child
  - was on probation or home placement at the time of commitment
  - is currently awaiting action on a previous alleged delinquent offense
  - is alleged to be an escapee or absconded from a juvenile facility, institution, or other court-ordered placement, or has within the previous twelve (12) months, willfully failed to appear at any juvenile court hearing, engaged in violent conduct resulting in serious injury to another person or involving the likelihood of serious injury or death, or been adjudicated delinquent by virtue of an offense constituting a felony if committed by an adult
- The child is an escapee from a secure juvenile facility or institution
- The child is wanted in another jurisdiction for an offense, which, if committed by an adult, would be a felony in that jurisdiction.

The Commissioner of Children Services or his/her designee has the authority to waive these criteria.

- In addition to the conditions listed above, there must be no less restrictive alternative than that which will reduce the risk of flight or of serious physical harm to the child or to others. No children in DCS physical or legal custody in foster care shall be placed, by DCS or with knowledge of DCS, in jail, correctional or detention facility unless such child has been charged with a delinquency charge or unless otherwise placed or ordered by the court

## **C. EDUCATION**

The facility must provide educational benefits to youth placed in the facility. Any credits earned by the child while in the detention center must be documented to ensure the earned credits will be recorded in the child's educational records and transferred to other systems when the child leaves the center.

## **D. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Room and Board
- Educational Services
- Case Management and Coordination
- Services outlined in Provider Policy Manual.

## **E. STAFFING ISSUES**

Detention center staff and staffing patterns must meet standards set by the Department of Children's Services. The facility must be certified and must abide by all certification guidelines established by the Department of Children's Services.

## **F. REFERRAL/ADMISSIONS**

A child placed in the physical or legal custody of the Department of Children's Services with an adjudication of dependent/neglect or unruly shall not be placed in jail, correctional facility, or detention center unless a child has been charged with a detainable delinquent offense or unless otherwise placed or ordered by court. (See Policy 16.49 Appendix E)

The Provider, through contracted arrangements with the Department of Children's Services, may serve only children referred by the DCS/CSA resource manager. All applicable admission requirements shall be met prior to placing any child in a detention facility. The Department of Children's Services shall be responsible for forwarding to the Provider all applicable records available on the child and shall notify the Provider of the need for any ongoing medical care.

## **G. CASE RECORD**

The detention facility shall be required to maintain a case record on each child that includes, at a minimum, the following information:

- All verbal and written information provided by DCS concerning the child and family
- Copies of all correspondence with DCS regarding the child and family

- Documentation of the child's adjustment to the program including reports of interactions with peers, interactions with those in positions of authority, any observed emotional or behavioral patterns, and reports of any disciplinary actions or offenses
- Education records generated or obtained by the Provider
- Medical records generated or obtained by the Provider
- Case recordings and all other documentation concerning contacts or developments in the cases of class members shall be added to the case file for that child within 30 days of the case work activity or development. The case files of class members shall contain adequate documentation tracking the services provided, progress, any change in placement of the child, and authorizations which document the approval for placements, treatment and services provided to each child.

## **H. TRANSPORTATION**

The Detention Center has the primary responsibility and must be willing and able to provide emergency medical transportation for children in the center. The Department of Children's Services will assume responsibility for other transportation.

## **I. CLOTHING**

Detention Centers are not required to purchase standard clothing for children placed in their facility. When uniforms are required by the facility, these uniforms will be provided by the facility.

## **J. DISCIPLINE AND SECURITY**

The use of corporal punishment and chemical restraints are prohibited. The use of mechanical restraints, pepper spray, and mace shall be restricted to cases in which the safety and security of the child or others is at risk.

**In order to utilize pepper spray, the provider must provide certified training and education that is to be documented in each authorized staff's personnel file.**

- **Appropriate medical attention must be provided and documented on each occurrence.**
- **Each time pepper spray or mace is administered, proper steps and medical attention must be administered in each occurrence to relieve the youth. Documentation must be provided in the youth's file of the medical attention and proper steps.**
- **A time lapse between administering the pepper spray or mace and appropriate medical attention cannot be used as a punishment.**

## **V. FOSTER CARE - GENERAL**

### **A. LEVELS OF FOSTER CARE INTENSITY**

There are three (3) levels or categories of foster care that relate to treatment intensity as well as medical needs. The three (3) levels are Foster Care, Therapeutic Foster Care and Medically Fragile **Foster Care**. These levels differ based upon:

- Program's ability to meet the individual treatment and/or medical needs of the child being served
- Frequency, intensity, and comprehensive nature of services offered both by the foster parents and the agency staff.
- Levels of training and specialized skills of foster parents required to meet children's needs.

### **B. SELECTION OF FOSTER PARENTS**

All foster parents must be screened for basic eligibility requirements including a background check fingerprinting check, ability to provide care, health, home's environment, and ability to meet their financial needs. Foster homes cannot exceed approved capacity. The TBI has now posted a listing of convicted sex offenders on the Internet ([www.ticic.state.tn.us](http://www.ticic.state.tn.us)). Current foster parents as well as prospective foster parents must be checked against the list. Documentation of the date this information was accessed should be made in the records maintained by the contract agency on each foster home. This requirement applies to any adult who is currently residing in the household or any adult who may in the future reside there while a foster child is in the household. A household with a **convicted** individual appearing on this list would not be an appropriate foster home.

Experience in working with children is recommended. Provider agency's staff may not also be foster parents for their employer. Neither may **foster parents** be immediate family of the employees of the agency that approves them as a foster home. Foster parents (and any other adult(s) in the household who may provide on-going and consistent care for the child) must complete a criminal background and fingerprinting and complete the required training (training must be the PATH curriculum – standards must be met for on-going training) for their level of care prior to approval. All household members must be interviewed and included in the foster home study prior to approval. The foster home study must be completed within sixty (60) days of the completion of the PATH training (see Appendix E - Administrative Policies and Procedures 16.4). (This interview of "all" members is an approval standard and should be appropriate to the age of the child **interviewed**.) Should the family composition change in any way subsequent to approval of the family for foster care, the agency must be informed and conduct another interview and home study amendment to determine the effect the change may have on the family's ability to continue in foster care effectively. Consideration of the home's physical capacity per approval standards must be made. If additional adults come into the household who may care for the child in any way, they must be considered as co-

applicants and must meet all requirements including basic screening and attendance and active participation in all required training.

**Foster families shall not exceed a total of six (6) children, including birth children, adoptive children, and foster children, in the home. No placement will result in more than three (3) children total under the age of three (3) residing in any foster home. Exceptions to this policy require prior approval as outlined in Brian A (see Exception Form). These restrictions do not apply to sibling groups as all efforts shall be made to keep sibling groups together. (See Policy 16.10 in Appendix E)**

### **C. FOSTER PARENT IN-SERVICE TRAINING\***

*\*in addition to the 30 hours required PATH Training (see Policy 16.4) in Appendix E.*

Each approved foster parent shall be required to have fifteen (15) hours of in-service training in the first year following approval, and then fifteen (15) hours of in-service training each successive year in order to remain in approved status with the Department of Children's Services foster care program.

#### **1. Procedures**

##### **a. Training during the first fiscal year following the year in which foster home approved**

- (1) All new foster parents are required to complete fifteen (15) hours of in-service training in the first fiscal year following the fiscal year in which they were approved.
- (2) The required in-service training for newly approved social services foster parents include:
  - (a) Discipline – 3 hours
  - (b) Sexual abuse – 3 hours
  - (c) Cultural competency – 3 hours
  - (d) Working with birth parents – 3 hours
  - (e) Elective – 3 hours
- (3) The required in-service training for juvenile justice foster homes shall include:
  - (a) Juvenile justice specific training (prior to approval – 9 hours)
  - (b) Sexual abuse (post approval) – 3 hours
  - (c) Cultural competency (post approval) – 3 hours

##### **b. Assessment of training needs**

- (1) Foster families are reassessed annually based on their approval date. Training received to date is reviewed at this time and families' training needs are identified. The case manager completing the reassessment will evaluate the families' ability to comply with the fiscal year's training requirement at this time and offer suggestions on training available. It is noted that the reassessment is tied to the families' approval date while the actual training requirements are based on a fiscal year calendar. This is

done on aggregate information about training needs from the families' reassessments completed over the past fiscal year.

- (2) Foster parents following their first complete fiscal year of service, after the fiscal year in which they were approved, shall be required to have a minimum of 15 hours per person, each year, to continue to be approved.
- (3) Training needs shall be documented. These training needs shall be met through the Contract Provider, regional Foster/Adoptive Parent Training Conference, other training offered by the foster/adoptive parent training contract and other community resources, individual use of video tapes and reading materials, etc., as outlined in section E of this policy.

**c. In-service training credit**

In-service training credit may be obtained in various ways:

- (1) Attendance at the annual, regional foster/adoptive training conference – *6 hours in-service training credit.*
- (2) Attendance at the annual conference of the Tennessee Foster Care Association – *12 hours in-service training credit.*
- (3) Special workshops on specific topics are offered through local foster care associations in conjunction with their meetings.
- (4) One-day workshops are offered on critical issues such as child sexual abuse, child discipline, etc.
- (5) Independent living training for foster parents and staff who work with adolescents to prepare them for life on their own.
- (6) Foster parents may also access computer-based training via the Internet. Central office program staff must approve any Website chosen as a training resource. Computer-based training will be limited to five (5) hours per person per year. Training hours related to reading books and reporting to the case manager will be limited to three (3) hours per year.
- (7) Other training options include special events offered by school systems, mental health facilities, and other public service resources. Journals, magazines articles, videotapes, and books may be used for individual study.
- (8) If there are extreme circumstances (extended illness, moving, death of a family member) that prevent foster parents from fulfilling their in-service training requirement, the Regional Administrator may grant a waiver for one year only. Foster parents would then be required to complete 15 hours of training the following year.
- (9) In-service training shall be documented on a yearly basis, from July 1 to June 30. There are no in-service requirements during the fiscal year in which a family is approved. All subsequent years, both parents are required to complete the required 15 hours of in-service training. Parents are encouraged to begin receiving in-service training from the point they are approved.

#### **D. AGENCY AND DCS' RESPONSIBILITIES TO FOSTER PARENTS**

**To the extent not otherwise prohibited by state or federal statute, the Department shall, through promulgation of rules in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, implement each of the following tenets. These tenets enforceable under the T.C.A. [37-2-415(a)] apply to foster parents contracted directly by DCS or through an agency which contracts with the department to place children in foster care:**

- To treat the foster parents with dignity, respect, trust and consideration as a primary provider of foster care and a member of the professional team caring for children
- To provide the foster parents with a clear explanation and understanding of the role of DCS, the contract agency and the role of members of the child's birth family in a child's foster care
- To permit the foster parents to continue their own family values and routines
- To provide the foster parents with training and support for the purpose of improving skills in providing daily care and meeting the special needs of the foster child
- To inform the foster parents prior to the placement of a foster child, of issues relative to the child that may jeopardize the health and safety of the foster family or alter the manner in which foster care should be administered (refer to the section following this area, indicated by asterisk [\*])
- To provide means by which the foster parents can contact the agency twenty-four (24) hours a day, seven (7) days a week for the purpose of receiving assistance
- To provide the foster parents timely and adequate financial reimbursement for the quality and knowledgeable care of a foster child
- To provide clear, written explanation of the plan concerning the placement of a child in the foster home. For emergency placements where time is not adequate to prior preparation of such explanation, such explanation will be provided as it becomes available. This explanation shall include but is not limited to all information regarding the child's contact with the birth family and cultural heritage, if so outlined
- To allow the foster parents, prior to placement, to review written information concerning the child and allow the foster parents to assist in determining if such child would be a proper placement for the prospective foster family. For emergency placements where time does not allow prior review of such information, information shall be provided as it becomes available
- To permit the foster parents to refuse placement within their home, or to request, upon reasonable notice to the agency, the removal of a child from their home for good reason, without threat of reprisal, unless otherwise stipulated by contract or policy
- To inform the foster parents of scheduled meetings and staffing concerning the foster child and permit the foster parent to participate in the case planning and decision-making process regarding the foster child. This may include

individual service planning meetings, foster care reviews, and individual educational planning meetings

- To inform the foster parents of decisions made by the courts or the child welfare agency concerning the child
- To solicit the input of the foster parents concerning the plan of services for the child and consider this input in the ongoing development of the plan
- To permit through written consent the ability of foster parents to communicate with professionals who work with the child, including any therapists, physicians, and teachers that work directly with the child
- To provide all information regarding the child and child's family background and health history, in a timely manner, to the foster parents. The foster parents shall receive additional or necessary information that is relevant to the care of the child on an ongoing basis, provided that confidential information received by the foster parents will be maintained as such by the foster parents, except as necessary to promote or protect the child's health and welfare
- To provide timely, written notification of changes in the case plan or termination of placement and the reasons for such, except in the instances of immediate response for child protective services
- To notify the foster parents in a complete manner of all court hearings, including notice of the date and time, the name of the judge or hearing officer hearing the case, the location of the hearing, and the court docket number. Such notification shall be made as soon as DCS informs the agency, which should be upon the department's receiving of this information, or at the same time that notification is issued to birth parents. Foster parents shall be permitted to attend such hearings at the discretion of the court
- To provide upon request by the foster parents to the department information regarding the child's progress after a child leaves foster care. Information provided pursuant to this subsection shall only be provided from information already in possession of the department at the time of the request
- To provide the foster parents the training for obtaining support and information concerning a better understanding of the rights and responsibilities of the foster parents
- **To consider the foster parents as the possible first choice permanent parents for the child, who after being in the foster parent's home for twelve (12) months, becomes free for adoption or permanent foster care**
- To consider the former foster family as a placement option when a foster child who was formerly in their care is to be re-entered into foster care
- To provide the foster parents appropriate periods of respite, free from placement of foster children in the family's home with follow-up contacts by the agency occurring a minimum of every two (2) months. The foster parents shall provide reasonable notice to the agency for respite
- (Effective February 1, 1998) Child abuse/neglect investigations involving the foster parents shall be investigated pursuant to the department's child protective services policies and procedures. A child protective services case manager from another area shall be assigned investigative responsibility. Removal of a foster child will be conducted pursuant to Tennessee Code Annotated and

departmental policy and procedures. The department shall permit an individual selected by the membership of the Tennessee Foster Care Association to be educated concerning the procedures relevant to investigations of alleged abuse and neglect by the department and the rights of the accused foster parents. Upon receiving such training, such individual shall be permitted to be present at all portions of investigations where the accused foster parents are present; and all communication received by such advocate therein shall be strictly confidential. Nothing contained within this item shall be construed to abrogate the provisions of chapter 1 of this title, regarding procedures for investigations of child abuse and neglect and child sexual abuse by the department of children's services and law enforcement agencies

- To provide upon request the foster parents copies of all information relative to their family and services contained in their personal foster home record
- To advise the foster parents of mediation efforts through publication in policy manuals and a foster parent handbook. The foster parents may file for mediation efforts in response to any violations of the preceding tenets.

In promulgation of rules pursuant to the introductory subsection (the first paragraph under C.), the department shall provide forth-five (45) days written notification of public hearings, held pursuant to the Uniform Administrative Procedures Act, compiled in Title 4, chapter 5, to the president of the Tennessee Foster Care Association and the president's designee. (Acts 1997, ch. 549, §§2,3.)

There are guidelines regarding the placement of children adjudicated delinquent in family foster homes, ***which contract agencies must follow***. Refer to Appendix E at the back of this manual to view Administrative Policies and Procedures: 16.1 entitled Placement of Delinquent Youth in Family Foster Homes.

**The Foster Home Placement Checklist meets criteria set forth by to the Foster Parent Bill of Rights. A copy of the Foster Home Placement Checklist (CS-0544) follows this page. At the time of placement of a child in a foster home, and no later than at the time the foster care placement contract is signed, the foster parent shall be provided a completed copy of the checklist with all information that is available to the department/contract agency. The form must be signed and dated by the agency representative providing information to the foster parent and the accepting foster parent. A copy of the form must be provided to the foster parent. A copy shall be forwarded to the home county case manager for filing. The original is placed in the agency's foster home file.**

### **1. Resolution of Foster Parents' Complaints**

Each contract agency that utilizes foster care must have in place an operational mediation process and grievance mechanism to handle and resolve all foster parent complaints in an equitable and timely manner. This must be on file and available for review. A copy of this must be submitted to the Director of Residential Monitoring Continuum Unit for approval. **The following process is modeled upon the mediation and grievance procedures set forth for the DCS Foster Care division:**

Any foster parent who determines that the contract agency/department is in violation of the Foster Parents' Bill of Rights or otherwise has a complaint should first discuss their concerns with the contract agency's foster care assigned to the foster home and attempt to work out an agreement. This step may involve showing the foster parent the written policy and procedures relative to approval of a foster home or ongoing casework activities. The contract agency's foster care must respond to the foster parent's complaint within three (3) working days.

If an understanding cannot be reached between the foster parent and the contract agency's foster care, the foster parent shall notify the agency's foster care casework supervisor and request assistance from that individual in mediating the conflict between the agency's foster care and the foster parent. The agency's foster care supervisor must respond to the foster parent within five (5) working days.

If the agencies foster care and foster care casework supervisor cannot make corrections or adjustments, the foster parents shall notify the contract agency's foster care coordinator in writing of their concerns and request an appointment with the foster care coordinator. This sets in place the grievance process. A scheduled meeting between all parties must take place within seven (7) working days of the receipt of the foster parent complaint. The results of the meeting shall be documented in writing within two (2) days of the meeting. The agency's foster care coordinator must then make a recommendation in writing for corrective action (or no action). Copies of the agency's foster care coordinator's decision/recommendation must be forwarded to all participants, and also to the DCS Director of Resource Management.

Within seven (7) days of the meeting/grievance hearing with the agency foster care coordinator; the foster parents may elect to file an appeal to a higher level. This may be forwarded to the DCS Director of Resource Management for review and recommendation and should include all the information/documentation of the foster parent's complaint(s), mediation and grievance meetings thus far. Copies of the final decision to approve or to modify the agency's actions must be forwarded to all participants.

## **E. STAFF POSITIONS/QUALIFICATIONS PERTINENT TO FOSTER CARE**

Qualifications for the foster care casework supervisor and the foster care relate to and are stated in the specific Licensing Standards For Child-Placing Agencies that are applicable to foster care placement.

**Staff qualifications as specified apply to staff hired as of July 1, 1994. Staff hired prior to that date may be "grand fathered in" provided they meet all state licensing requirements.**

### **1. Program Director**

**Definition---**The Program Director is located on site and is responsible either directly or indirectly through delegation for the following responsibilities:

- Agency planning

- Budget preparation
- Recruitment, selection and hiring of employees
- Training
- Interpretation of the agency's program to the community
- Implementation of the agency's policies and procedures

In small programs, the Program Director may also be responsible for providing treatment or supervising treatment staff. In this situation (or any other in which a staff member fulfills the roles/responsibilities of more than one position) the Program Director must meet all the qualifying requirements for the position that typically has that job responsibility.

**Qualifications of Program Director**---must have a minimum of a **Bachelor's degree** in the social sciences, business, education or an allied field. A minimum of **two (2) years** of experience working in a childcare agency is required. Experience in a residential setting is preferred. Program management experience is desirable.

## **2. Foster Care Casework Supervisor**

**Definition**--- In most agencies, the Foster Care Casework Supervisor is the direct supervision of the child care workers. The Foster Care Casework Supervisor responsibilities include:

- Review and approval of individual treatment plans for children and/or families
- Supervision of all casework being provided by treatment staff
- Training of treatment staff

**Qualifications of the Foster Care Casework Supervisor** --- with supervisory responsibility for case managers or caseworkers shall have a minimum of a **Master's degree** in social work or related behavioral field with a child or family focus (excluding criminal justice) and at least three years experience as a caseworker in child welfare; however, an additional 2 years of providing child welfare services may substitute for the master's degree. (This sentence does not apply to supervisors currently holding their positions as of October 1, 2001.)

## **3. Foster Care**

**Definition**---The is generally a full-time employee of the agency. Some agencies may contract for part-time casework services. The is the "front line" worker with children. responsibilities include:

- Participation in the development of treatment plans
- Implementation of individual treatment plans (if applicable) for the children and/or families
- Maintenance of casework documentation and progress notes
- Therapeutic support to children regarding educational goals, anger control, grief issues, separation issues, and other personal and family issues
- Provision of crisis intervention
- Transportation of children/family as necessary

- Review of and recommendations for foster parent's supervision of children's activities including household chores and recreational activities
- Facilitation of group process and structured treatment activities

**Qualifications of the Foster Care** ---must have a minimum of a **Bachelor's degree** with a major in social work or a related field such as psychology or sociology and **one (1) year** of pertinent experience in the human services field with children or in a residential treatment setting. Volunteer experience, practicum and intern experiences in programs/facilities that work with children and families may be counted as pertinent work experience. A Master's degree in the social sciences may be substituted for the one year of work experience.

#### **4. Clinical Service Provider**

**Definition**---The Clinical Service Provider is an appropriately licensed and certified professional who may work directly with children and families or may serve as treatment and program consultants to the agency's and casework supervisor staff. This individual may be on-staff with the agency or may be a contracted service provider.

**Qualifications of the Clinical Service Provider**---must be appropriately licensed and certified and be a medical doctor or have a **Master's degree, Ed.D., Ed.S., or Ph.D.** in the behavioral sciences with a minimum of **three (3) years** of pertinent work experience since receiving the advanced degree. Five years of pertinent experience is desirable. The clinical service provider's area of concentration or experience should be appropriate to the issues of consultation. An individual with a Master's degree who is on a licensure tract and under the supervision of a licensed practitioner is acceptable as a clinical service provider. All required documentation for licensure tract and supervision should be included in the personnel file of the Clinical Service Provider.

#### **5. Others**

The child-placing agency may also utilize case aides and others who may assist in service delivery. These individuals shall have specific job assignments.

#### **6. Staff Training Issues**

**The Provider must provide curriculum and material for staff training for review and approved to the Director of Training, Department of Children's Services.**

The Provider must provide and properly document in each employee's personnel file the following training to all full and part-time child care staff, supervisory staff, all foster care staff (all levels), or others who have any supervisory responsibility for children:

- 80 hours of pre-service instructional training
- 80 hours of pre-service supervised field training
- 40 hours of ongoing training each year

No case manager shall assume responsibility for a case, except as part of a training caseload, until completion of training.

College credits in an applicable social science earned within the current year may be substituted for annual training in the following manner:

- Two and two-thirds ( $2\frac{2}{3}$ ) training hours per each quarter hour of college credit completed
- Four (4) training hours per each semester hour of college credit completed

**Qualifications of Case Manager 1**---shall have a Bachelor's degree in social work or related behavioral science.

**Qualifications of Case Manager 2**---shall have at least a Bachelor's degree in social work or related behavioral science and one year experience in providing child welfare services.

**Qualifications of Case Manager 3**--- shall have at least a Bachelor's degree in social work or related behavioral science and two years experience in providing child welfare services. A master's degree in social work or related behavioral science, may substitute for one year's experience in providing child welfare services.

**7. Caseload, Supervision and Agency Caseworker Visits**

- No Case Manager 1 having responsibility for the case of any class member shall have a case load totaling more than 15 class members
- No Case Manager 2 or 3 having responsibility for the case of any class member shall have a case load totaling more than 20 class members
- Case Managers with an adoptions caseload shall not have a caseload totaling more than 12 children in the plaintiff class
- Case Manager 3s having no supervisory responsibility shall not have a caseload of more than 20
- Case Manager 3s that supervise shall have a weighted caseload
- Case Manager 3s supervising up to two lower level Case Managers shall not have caseloads totaling more than 10. A Case Manager 3 supervising three or more lower level Case Managers shall not have a caseload.

A Case Manager 3 shall not supervise more than 4 Case Managers. Case Manager 3s shall be given supervisory responsibility only in circumstances in which the caps on supervisory caseloads dictate that an additional Case Manager 4 would have less than a full supervisory case load.

For children in a foster home or facility operated by a contract agency, the agency shall require and ensure that the private agency caseworker visits the child as frequently as necessary to ensure the child's adjustment in placement, to ensure the child is receiving appropriate treatments and services, and to determine that the child's needs are being met and service goals are being implemented. Visits may take place in the child's placement, at school if the child is of school age, in the case manager's office, or in another appropriate setting. Worker-child visiting shall mean a face-to-face visit between the child's agency caseworker and the child. Visits shall include a private meeting between agency caseworker and the child out of the

presence of the foster parents or caretaker, except for those cases in which the child is an infant. **There shall be at least 6 face-to-face visits during the first 8 weeks a child is in a new placement, and at least 3 of these visits shall take place in the child's placement. During the second 8 weeks the child is in a new placement, there shall be at least 1 face-to-face visit every 2 weeks. Following the first 16 weeks a child is in a new placement, there shall be at least 2 face-to-face visits each month.**

#### **F. LEAVE/TRANSITION**

A child may experience approved leave from a program for up to fifteen (15) days, and the DCS Provider may be reimbursed. Such leave may include visiting family or going to summer camp. Approved leave must be in writing from the Regional Administrator or designee, and does not include the time a program may be closed for a weekend or holiday. The DCS Provider must be open and available to provide services during this period of time in order to receive compensation.

#### **G. OTHER REQUIREMENTS/REMINDERS**

With the approval of the agency to which the family is affiliated, respite care *will* be authorized for the foster family as deemed appropriate and necessary. *(Under the Foster Parents' Bills of Rights, a respite period must be offered at a minimum of every 2 months.)* **It is the responsibility of the Provider to pay for respite services.**

Agency staff and agency staff relatives are not permitted to take a child home on an overnight basis or for other reasons including working in staff's homes.

Employees, ***immediate relatives of employees***, or contracted agents of the Provider agency shall not be approved as foster parents for any child placed in the DCS Provider's program. **They** may be approved as a DCS or another agency foster home.

The Provider shall adhere to all inquiries for information made by the State, or agencies authorized by the State, within the time frames designated.

The Provider shall maintain crisis intervention services for children available twenty-four hours per day, seven (7) days per week including holidays. A crisis intervention plan must be operational and on file for review. In the event, a youth has excessive medical, emotional, or behavioral issues, the Provider will develop and implement an Individual Crisis Management Plan for that youth.

***No child shall be placed in a foster home if that placement will result in more than three foster children in that foster home, or a total of six children, including the foster family's birth and/or adopted children. No placement will result in more than 3 children under the age of 3 residing in a foster home. If an exception to this is in the best interest of the child, approval is needed from the regional assistant commissioner. All children shall be placed in accordance with their individual need; that is***

*placement as close to his/her home and community as possible, the need to place siblings together and the need to place children in the least restrictive, most home-like setting possible. (See Policy 16.46 Appendix E)*

*Siblings who enter placement at or near the same time shall be placed together, unless doing so is harmful to one or more of the siblings. If entering separately, efforts should **also** be made to keep siblings together. (See Policy 16.10 in Appendix E)*

*Minimum payments to foster parents: All board rates to foster parents will at a minimum meet USDA standards and will be adjusted annually to be no lower than USDA standards for the cost of raising children.*

**Board Rate Minimum to Foster Parents Per Day:**

*(See Policy 16.29 Foster Care Board Rates in Appendix E.)*

<b>AGE</b>	<b>USDA</b>
<b>0-2 years</b>	<b>\$13.84</b>
<b>3-5 years</b>	<b>\$14.02</b>
<b>6-8 years</b>	<b>\$15.23</b>
<b>9-11 years</b>	<b>\$15.95</b>
<b>12-14 years</b>	<b>\$18.41</b>
<b>15 and up</b>	<b>\$17.75</b>

## **H. DISCIPLINE**

Foster families are prohibited from using corporal punishment, chemical restraints, or mechanical restraints in disciplining or controlling children placed in their care. Each foster family must develop a behavior management plan for use with the child/children placed in their home. This plan must be approved by the agency with which the family is affiliated and be maintained in the agency's case file for each child.

## **VI. LOW INTENSITY TREATMENT FOSTER CARE**

### **A. PROGRAM DESCRIPTION**

Foster Care is a service provided in a family, approved and trained by an agency licensed to recruit, train, and place youth into foster homes.

### **B. POPULATION SERVED**

Children eligible for this level of foster care may be abused and/or neglected, exploited, exhibit runaway and/or delinquent behavior, and need an individualized placement in a family setting. These children may exhibit behavioral and/or emotional problems, which range from acting out to withdrawal. Emergency Foster Care is particularly appropriate for younger children, but may also be available for older children. Those children appropriate for independent living foster care are ages 16-21 who are in need of developmental activities and supportive services which will enable them to live on their own.

Children needing this service are basically in good health, although they will require medical care for routine health problems.

Emergency Foster Care is available on a twenty-four (24) hour basis. Parents providing this type of care must have training in crisis and emergency measures and procedures.

Foster Care is available for those children diagnosed as developmentally delayed and in need of family care.

At this level of care, children typically:

- Have behavior under control and do not require extraordinary adult supervision
- Respond to a family environment in a positive manner.

Educational services should be available through the public school system, and may, if appropriate include special education.

### **C. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Foster Parent Training, Recruitment, and Retention Services
- Foster Parent respite
- Room and Board
- Counseling
- Case Management Consultation and Coordination Services
- School Liaison
- Coordination with family members as outlined by the Department of Children's Services.

## **D. DEFINITIONS OF SERVICES**

### **3. Foster Care Low Intensity**

An individualized placement service that provides out-of-home care in a private family residence for children and youth who have been abused, neglected, or are in imminent danger of being abused and can no longer remain in their own home. These children may exhibit run away or delinquent behaviors. Youth may exhibit behavioral and/or emotional problems, which range from acting out to withdrawal. These youth are basically healthy, although some may require medical attention for minor health conditions. This service is appropriate for those children and youth whose problems are not severe enough to warrant more intensive treatment and can live successfully in a family setting.

### **4. Foster Care Emergency**

A service designed to provide a home environment for children during a time of crisis. These youth may be abused, neglected or exploited, or be in imminent danger of being abused, neglected or exploited, and require removal from their own home or residence. Youth may exhibit runaway or delinquent behaviors, or require an assessment for placement. Youth may display behaviors characteristic of one in crisis. Such behaviors may range from acting out to withdrawal. Foster parents are trained on crisis intervention techniques to de-escalate such behaviors. This service is available on a twenty-four (24) hour basis to provide immediate shelter and nurturing to those children removed from their homes or from other settings.

### **5. Foster Care Independent Living**

This program provides for specialized foster care for older adolescents who cannot return home and need training in independent living skills. Foster parents receive specialized training in independent skills so that they may effectively train youth in these skills.

## **E. CHARACTERISTICS**

- Low intensity treatment
- Low staff/high caseload ratio

## **F. CATEGORIES OF LOW INTENSITY TREATMENT FOSTER CARE**

- Foster care: low intensity
- Foster care emergency
- Foster care independent living

## **G. STAFF RATIO**

Staff caseloads will not exceed a 1:20 ratio.

## **H. INELIGIBLE YOUTH**

Ineligible youth are those who are actively suicidal, homicidal, or who have displayed violent acts within the past year, or children with extreme behavioral, physical, or emotional problems.

## **I. REQUIRED TRAINING FOR FOSTER PARENTS AT THIS LEVEL**

It is preferable that the PATH training program currently being utilized by the State's DCS Foster Care division be utilized prior to the placement of children, pick up after thirty (30) hours and another fifteen (15) hours within ninety (90) days of placement. Low intensity treatment foster care foster parents shall be trained a minimum of thirty (30) hours. A minimum of ten (10) hours of in-service training hours per year shall be required for all approved foster parents at this level. (This includes the first year.) The 10 hours required in-service training for newly approved foster parents should include advanced courses on discipline, sexual abuse, and cultural diversity. (see Policy 16.4 in Appendix E)

## **J. CASE RECORD REQUIREMENTS**

Weekly progress notes are required in the case record of each child. Progress notes must be based on the progress of the child and family in meeting identified treatment objectives, and should also include information on any significant incidents, home passes, and/or new treatment needs being evidenced by the child and/or family. Case recordings and all other documentation concerning contacts or developments in the cases of class members shall be added to the case file for that child within 30 days of the case work activity or development. The case files of class members shall contain adequate documentation tracking the services provided, progress, any change in placement of the child, and authorizations which document the approval for placements, treatment and services provided to each child. On at least a quarterly basis, a progress report/treatment summary on each child in the program will be forwarded to the DCS case manager and the DCS/CSA resource manager for review. The IPP/Treatment Plan must be reviewed/modified whenever indicated, but at least quarterly. The plan and documentation must reference the child's permanency plan. The permanency plan shall establish realistic goals for the family, the child/youth, and the department necessary to achieve permanency of the child/youth. The permanency plan shall identify the permanency goal or concurrent permanency goals for the child/youth.

## **VII. FOSTER CARE THERAPEUTIC**

### **A. PROGRAM DESCRIPTION**

Foster Care Specialized program shall provide recruitment, training, and support services to foster parents trained to meet the needs of youth who are appropriate for family based care but require a higher level of behavioral intervention, case coordination, and/or counseling services. These foster parents require more frequent respite and support services and training in behavioral intervention.

### **B. POPULATION SERVED**

Effective July 1, 2000, placement of children requiring this level of foster care (i.e., therapeutic foster care) is limited to two (2) therapeutic children (excepting a sibling group which may include more than 2 therapeutic-level siblings) per foster home. Although there may occasionally be certain exceptional cases for review of the Director of Residential Continuum Monitoring Unit, waivers will not be routinely granted.

Children in foster homes that have already received waivers of the policy effective 7/1/99-6/30/00 may remain in their placements as long as such placement is stable and considered by the child-placing agency to be in the best interest of the child/children to remain in that placement. However, the waiver will not continue once youth have moved from the home.

This level of foster care is available to children who can benefit from a family based treatment model. These children exhibit behavioral, emotional, or social problems that are of such a nature that they disrupt academic and developmental progress, family relationships, and hinder overall functioning. The Department of Children's Services (DCS), and DCS Provider staff shall evaluate children who receive Level II therapeutic care every three (3) months to determine if the need for therapeutic foster care persists. Children at this level typically require counseling services, provided through the agency as part of the per diem rate. If therapy is necessary, this should be accessed through TennCare.

At this level of care, children typically:

- Have need of treatment to be able to function in the community setting
- Have not responded successfully to less intensive treatment and/or have had numerous unsuccessful placements
- Respond to a family setting in a generally positive manner when the foster parents are trained to provide therapeutic behavior management
- Have successfully responded to residential treatment and are ready for re-integration into the community.

Therapeutic foster parents must be trained in the provision of behavioral management techniques and various treatment approaches. Out-of-home individual counseling as an extension of in-home treatment shall be available as needed.

These children should be able to attend public schools. Some children may require special education programs or day treatment.

Some children may also have special needs that will require adjunct and specialized services. Such services can be accessed by utilizing community resources or through agency services.

Routine respite care is required to prevent “burn out” among foster parents.

#### **C. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Foster Parent Training, Recruitment, Retention Services
- Foster Parent respite
- Room and Board
- Counseling
- Case Management Consultation and Coordination Services
- School Liaison
- Coordination with family members as outlined by the Department of Children’s Services.

#### **D. DEFINITIONS OF SERVICES**

##### **1. Therapeutic**

This service provides foster family based treatment to children and youth who exhibit behavioral, emotional or social problems that hinder their overall functioning, or to children with mental retardation or developmental disabilities who cannot be served in regular foster care programs. Component features of this type program include: a professional staff of s who support the therapeutic foster families and youth by providing a range of services such as intensive supervision, the arrangement of individual counseling as an extension of in-home treatment as needed, liaison services, twenty-four (24) hour in-home emergency service, and coordination of medical treatment and physical therapies when necessary, recruitment and training of foster parents in behavioral management techniques and various treatment approaches, documentation and tracking of youth progress, and emphasis on the professionalism of foster parents by providing an enhanced stipend and opportunities for ongoing training.

#### **E. CHARACTERISTICS**

- High intensity treatment
- High staff/low caseload ratio

#### **F. CATEGORIES OF FOSTER CARE SPECIALIZED**

- Foster care therapeutic

#### **G. STAFF RATIO**

Staff caseloads shall not exceed a 1:10 ratio.

#### **H. INELIGIBLE YOUTH**

Ineligible children are those who are actively psychotic, homicidal or suicidal, and cannot function in a family setting.

#### **I. FOSTER PARENT TRAINING REQUIRED AT THIS LEVEL**

Therapeutic foster parents shall be trained a minimum of forty-five (45) hours (15 hours in addition to the number of training hours required in the PATH foster parent training program that is currently being utilized by the State's DCS Foster Care division) prior to placement of a child in their home. Core hours should be PATH training. The additional fifteen (15) training hours required for therapeutic foster care involve specialized training necessary to competently care for the greater needs of the foster children at this level. A minimum of fifteen (15) hours of in-service training per year will be required for approved foster parents. (This includes the first year.) Ten (10) hours of the in-service training hours for newly approved foster parents should include advanced courses in discipline, sexual abuse, and cultural diversity.

#### **J. CASE RECORD REQUIREMENTS FOR ALL CHILDREN AT THIS LEVEL**

*(including foster care, foster care therapeutic, and foster care medically fragile)*

Daily progress notes are required in the case record of each child. Progress notes must be based on the progress of the child and family in meeting identified treatment objectives, and should also include information of any significant incidents, home passes, and/or new treatment needs being evidenced by the child and/or family. Case recordings and all other documentation concerning contacts or developments in the cases of class members shall be added to the case file for that child within 30 days of the case work activity or development. The case files of class members shall contain adequate documentation tracking the services provided, progress, any change in placement of the child, and

authorizations which document the approval for placements, treatment and services provided to each child. There must be a minimum of one week face-to-face contact with the client by staff and a minimum of one home visit a month documented in the case record progress notes. A monthly progress summary must be provided to the DCS home county case manager and to the regional resource manager for review. The IPP/Treatment Plan must be reviewed and updated/modified whenever indicated, but at least quarterly. All members of and participants in the treatment team must receive adequate notice of and be encouraged to attend such staffing. The plan and documentation must reference the child's permanent plan.

## **VIII. FOSTER CARE MEDICALLY FRAGILE**

### **A. PROGRAM DESCRIPTION**

Foster Care Medically Fragile program shall provide recruitment, training, and support services to foster parents trained to meet the needs of youth who are appropriate for family-based care but require a higher level of medical support, intervention, and case coordination. These foster parents require more frequent respite, support services and training specifically tailored to meet the medical needs of the children and youth in their home.

### **B. POPULATION SERVED**

This is a foster care program provided in a private family residence by caretakers who are specially trained to care for children with extreme medical needs, which cannot be provided in their family homes. This program is offered to children with serious medical needs who would otherwise remain in a hospital or other medical settings.

Placement of children requiring this level of foster care is limited to one child per foster home. The DCS Regional Health Unit nurses have been given the responsibility to “gate keep” the medically fragile youth and authorize the initial and ongoing placement in this scope of service.

Children who receive medically fragile foster care should be evaluated by the Department of Children’s Services Regional Nurse, Resource Management, and Provider staff, and if appropriate, medically staff the case every month to determine if the need for this intense level of foster care continues.

Counseling may be available on an out-of-home basis if appropriate. Foster parents must be trained to help the children deal with his or her disability. Foster parents must also be trained on dealing with a terminal illness.

Routine respite care is required for all foster parents at this level of foster care.

Education in the public schools is not possible for many of these children. Foster parents must work with the Local Educational Agency (LEA) and s in determining the best educational plan.

### **C. DEFINITIONS OF SERVICES**

Children eligible for this program have medical conditions with extraordinary needs. Foster parents must be trained in giving medical care including cardiopulmonary resuscitation (CPR), first aid, and other specific medical care needs of the child. Some of these children have terminal illness and may also have history of various form of abuse.

At this level of care, children typically:

- Are symptomatic HIV positive children
- Are drug exposed infants who require intense caregiving
- Are infants diagnosed at birth with serious medical conditions requiring strict medical follow-up and/or frequent hospitalization
- Are children between 1 and 3 years of age who, due to serious neurological or other medical conditions are significantly developmentally delayed and require extraordinary caregiving
- Are children over age 3 who are unable to provide any personal care (grooming, bathing, eating, toileting, ambulating, etc.) for themselves
- Are children who test positive for HIV at birth. Should they later test negative; for HIV (3 negative tests by age 2), they should be transitioned to regular care
- Are children at any age who require specialized medical treatment in the home including:

Tracheotomy care

Gastrostomy care

Broviac Catheter Intravenous central line care

Apnea monitoring

Home oxygen therapy

Dialysis

Bladder catheterization care

Burn care (extensive skin and body care)

Wound care (severe)

Percussion therapy for cystic fibrosis

Factor 8 infusion therapy for Hemophilia

Naso/gastric feeding

Administration of complex medications and special therapies by the caregiver

Terminal Illness Care

Specialized sterilization practices.

#### **D. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Room and Board
- Counseling Services/Crisis Stabilization
- School liaison
- Social Services/Case Management and Coordination
- Foster Parent recruitment, training, approval
- Respite services for foster parent(s)
- Specialized training and medical coordination.

#### **E. CHARACTERISTICS**

- High intensity medical care/treatment
- High staff/low caseload ratio

## **F. STAFF RATIO**

Staff caseloads shall not exceed a 1:10 ratio.

## **G. INELIGIBLE YOUTH**

Ineligible Youth are those whose health and medical needs are not considered extreme or severe, and do not require specialized in-home medical care. Some agencies may offer a step-down level for those children whose medical problems or disabilities improve, but the children continue to need medical care and assistance at a less intense level. These children would not necessarily continue to meet the medical conditions listed above to be eligible for the service. However, they must continue to have substantial special medical needs to remain at the step-down level. Children who no longer require special medical care and assistance should be transitioned to regular foster care.

## **H. TRAINING REQUIRED FOR MEDICALLY FRAGILE FOSTER PARENTS**

### **1. Procedures**

#### **a. Criteria**

- (1) A one-parent foster home shall not care for more than one medically-fragile child and shall demonstrate that support services are available and will be provided as needed. A single parent with a medically-fragile child by birth or adoption will not be approved to provide foster care for another medically-fragile child.
- (2) If a single parent desires the placement of a medically-fragile foster child and already has two or more healthy birth, adopted or foster children in the home, the Quality Assurance Division must grant a waiver for the single parent to accept a placement of the child with extraordinary medical needs.
- (3) A two-parent home shall not care for more than two medically fragile children including the foster parent's own medically-fragile child. For instance, if the foster parents already have a medically-fragile child by birth or adoption, then they can only be approved for the placement of one medically-fragile foster child.
- (4) An exception may be approved by the Quality Assurance Division for the number of children in a foster home that has live-in or daily staff support, and when it is determined that the particular needs of all the children and the subsequent demands on the foster parent are met.
- (5) The medically fragile foster home shall be within one hour of a medical hospital with an emergency room and within 45 minutes of a local medical facility.

#### **b. Training requirements**

- (1) Foster parents who provide care for medically fragile children shall meet the same requirements for initial approval as regular foster parents. However, they shall have fifteen (15) additional training hours in the areas of:
  - (a) Growth and development

- (b) Nutrition
- (c) Medical disabilities
- (d) Current certification in CPR
- (e) Current certification in first aid
- (2) The local Public Health Department and/or the Medical Center are good sources to secure the above training. For training on the issues of caring for children who are HIV+ or have AIDS, the curriculum, *Hugs Invited*, is available to be checked out through the DCS central office. Also available are handouts from the book *Caring for Children With Special Health Care Needs: A Foster Manual for Tennessee Families*, a foster care book for case managers and caregivers written in collaboration with the University of Tennessee School of Medicine in Memphis.
- (3) The following may be used, hour for hour, to meet the on-going training requirements of 20 hours:
  - (a) Planned meetings among medically fragile foster parents conducted by a social worker or case manager.
  - (b) Participation in an organization associated with or having an interest in medically fragile foster children.
  - (c) Attendance at workshops sponsored jointly by the Department and UT SWORPS.
  - (d) Individualized professional training from the medical profession related to the individualized needs of the child.

## **I. CASE RECORD REQUIREMENTS FOR ALL CHILDREN AT THIS LEVEL**

Daily progress notes are required in the case record of each child. Progress notes must be based on the progress of the child and family in meeting identified treatment objectives, and should also include information on any significant incidents, home passes, and/or new treatment needs being evidenced by the child and/or family. Case recordings and all other documentation concerning contacts or developments in the cases of class members shall be added to the case file for that child within 30 days of the case work activity or development. The case files of class members shall contain adequate documentation tracking the services provided, progress, any change in placement of the child, and authorizations which document the approval for placements, treatment and services provided to each child. In recognizing the intensity of needs of medically fragile children in Medically Fragile Foster Care Services, the requirement is for minimum weekly staff supervisory oversight as indicated in the child's treatment plan. This should be noted in the case record. A monthly progress summary must be provided to the DCS home county case manager and to the regional resource manager for review. The IPP/Treatment Plan must be reviewed and updated/modified whenever indicated, but at least quarterly.

## **IX. LEVELS OF RESIDENTIAL TREATMENT INTENSITY**

There are levels of treatment intensity for residential treatment. The levels of treatment intensity differ as based upon:

- The program's ability to meet the individual treatment demands of the child being served
- Supervision needs required for the program (high staff/child ratio versus low staff/child ratio)
- Frequency, intensity, and comprehensive nature of services offered
- Absence or presence of a day treatment/educational program component
- Need for medical staff
- Need for adjunct or specialized services to meet treatment demands
- Children shall not be placed in a residential treatment center or other group care setting with a capacity in excess of eight (8) children without express written approval by the Regional Administrator. (See Policy 16.47 Appendix E)
- Children under six years (6) of age shall not be placed in a group care non-foster home setting, except for children with exceptional needs that cannot be met in any other type of placement. (See Policy 16.45 Appendix E)

## **X. LEVEL I RESIDENTIAL PROGRAMS AND LEVEL I SPECIALIZED RESIDENTIAL PROGRAMS**

### **A. CHARACTERISTICS**

- Low intensity treatment programs
- Low staff/low supervision

### **B. GENERAL DESCRIPTION**

Level I Residential Services provide services in a group home or residential facility. Services include support and counseling, behavioral intervention, and other needs identified in a child's Permanency Plan for **child**/youth with mild clinical needs. Children in this program type attend public school in the community.

### **C. POPULATION SERVED**

Children eligible for this level program may be abused, neglected, or exploited. These children can no longer reside in their own home or residence. These children may exhibit runaway or delinquent behavior. They may exhibit behavioral and/or emotional problems, which range from acting out to withdrawal.

This population has mild to moderate difficulty attributable to stressors, which hinder overall functioning in social, school or occupational tasks.

The Scope of Service does not generally require serving children with moderate or more severe mental retardation unless the program was established to serve this population. However, the Department of Children's Services (DCS) Provider must review any such child referred on a case-by-case basis to determine if the child could be appropriately served. A diagnosis of mental retardation must not be used as a basis to refuse admission of a child when the child's behavioral issues fall within the program's Scope of Services. A diagnosis of mental retardation must be based on assessment of both the child's intellectual and adaptive level of functioning. The assessment must be graded according to professionally accepted instruments.

Children needing Level I services are basically in good health, although some may require medical attention for minor health conditions.

At this level, children typically:

- Have behavior which is under control and does not require constant adult supervision
- Have peer relations that are generally positive
- Are generally compliant with staff and respond favorably to nurturing; structured programs

- Do not pose a safety risk to the community or other children in the facility.

Pregnant females are eligible only for admission (for residential care) to a facility licensed as a maternity home.

#### **D. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Counseling - generally consists of social services to provide guidance, address general adjustment issues, encourage the development of skills needed for improved psychological functioning, and assistance in the reunification of families whenever possible. When reunification is not a viable option, then preparations for independent living becomes the goal
- Support Services - generally consists of social services to provide guidance, address general adjustment issues, encourage the development of skills needed for improved psychological functioning, and assistance in the reunification of families whenever possible. When reunification is not a viable option, then preparations for independent living becomes the goal
- School Liaison
- Room and Board
- Coordination with family as outlined on the Permanency Plan and approved by DCS
- Educational Services - children or youth in a Level 1 program shall participate in the most normalized educational setting possible, which in most cases, should be the local public school. Children appropriate for this level of care must be enrolled in the local public school system.

#### **E. DEFINITIONS OF SERVICES**

##### **1. Residential Treatment Center (RTC) Level I**

**This level of care is characterized by** low treatment intensity, **and** low supervision needs. Youth who are eligible for this level program may be abused, neglected, or exploited. Youth may exhibit behavioral and/or emotional problems, which may range from acting out to withdrawal. Appropriate youth are basically in good health, although some youth may require medical attention for minor health conditions. These youth can have their educational needs (regular and special education classes) met through the public school system.

##### **2. Independent Living**

This program is for youth ages 16-21 who have been separated from their homes and disconnected from long-term family relationships and who need the skills necessary to lead self-sufficient, healthy, productive and responsible lives.

##### **3. Residential Level I Maternity**

**This is** a program licensed as a maternity program, providing a protective, supportive environment for pregnant females in preparation for childbirth, and post delivery, **who**

live in the community. Principle features include: support services, educational services, and prenatal, labor, delivery and postpartum care.

## **F. INELIGIBLE CHILDREN**

Ineligible children are those who are actively suicidal, homicidal, or who have displayed violent acts of aggression within the past six (6) months, which have caused them to be brought before juvenile authorities and adjudicated for these acts.

## **G. CASE RECORD**

Weekly progress notes are required in the case record of each child. Progress notes must be based on the progress of the child and family in meeting identified treatment objectives, and may also include information on any significant incidents, home passes, or new treatment needs being evidenced by the child and/or family. Case recordings and all other documentation concerning contacts or developments in the cases of class members shall be added to the case file for that child within 30 days of the case work activity or development. The case files of class members shall contain adequate documentation tracking the services provided, progress, any change in placement of the child, and authorizations which document the approval for placements, treatment and services provided to each child. Documentation of milieu treatment with schedule for all residential programs must be included in the client file. On at least a quarterly basis, a progress report/treatment summary on each child in the program is to be provided to the DCS case manager and the regional resource manager for review. The IPP/Treatment Plan is to be reviewed and updated/modified whenever indicated, but at least quarterly. The plan and documentation must reference the child's permanent plan.

All members of and participants in the treatment team must receive adequate notice of and be encouraged to attend such staffings. NOTE: All procedures must be carried out in compliance with the DCS Appeals Process.

## **H. STAFFING PATTERN**

The Provider shall ensure the following minimum staffing patterns:

- Residential Group Care - 1:8 ratio; staff are not required to be awake at night
- Residential Independent Living - 1:10 ratio; staff are not required to be awake at night

Mother/Baby programs shall adhere to a 1:8 staffing ratio, in adherence to applicable licensing requirements.

## **I. TRANSITION**

A child may transition from a Level I program into foster care. The transition may last up to two (2) months per each foster home placement attempted. The Department of

Children's Services Regional Administrator shall approve the transition plan. The Provider shall be paid for days of service the child visits the foster parents for up to a maximum of fifteen (15) days per each foster home placement attempted in accordance with the approved plan. The foster parents may also be reimbursed for days of service when the child is with them.

## **XI. LEVEL II RESIDENTIAL PROGRAMS**

### **A. CHARACTERISTICS**

- Moderate intensity treatment programs
- Moderate staff/moderate or high supervision

### **B. PROGRAM DESCRIPTION**

Level II Residential Services is a structured group home or residential treatment facility which provides structure, counseling, behavioral intervention, and other needs identified in a child's permanency plan for youth with moderate clinical needs. Children in this program type attend public school in the community.

### **C. POPULATION SERVED**

Children eligible for this level program must have a Diagnostic & Statistical Manual, Fourth Edition (DSM-IV) diagnostic mental illness or be identified by a mental health professional as having at least moderate emotional and/or behavioral problems and be in need of treatment. Children may also have Level II substance abuse needs or have had Level III substance abuse needs and have successfully completed an Alcohol and Drug Treatment Program. Children may be delinquent, chronic runaways, display manipulative behaviors, have difficulty maintaining self-control, display poor self-esteem, have difficulty in securing and maintaining close relationships with others, be habitually truant from school and have difficulty in accepting authority. Children with a history of sexual offenses are eligible if they have successfully completed a sex offender treatment program and/or have been deemed not to pose a serious risk by a recognized sex offender treatment professional.

These children have not responded successfully to less intensive interventions or have been denied admission or discharged from less intensive placements because of their emotional or behavioral problems. The behavior of these children is not well controlled without constant adult supervision. Some children may be in need of psychotropic medication.

The Level II Department of Children's Services (DCS) Provider, must review youth with developmental delays on a case-by-case basis to determine if the child could be appropriately served. A diagnosis of mental retardation must not be used as a basis to refuse admission to a child when the child's behavioral issues fall within the program's Scope of Service. A diagnosis of mental retardation must be based on assessment of both the child's intellectual and adaptive level of functioning. The assessment must be graded according to professionally accepted assessment instruments.

Children needing Level II services are basically healthy. Routine medical attention for minor health problems or for monitoring medication may be required.

Pregnant females admitted before the third trimester who have no major health problems, which would hinder participation, are also eligible.

At this level, children typically:

- Have need of clinical treatment to be able to function in school, home, or the community because of multiple problems
- Have not responded successfully to less intensive treatment and/or have been denied admission or discharged from various placements because of emotional and behavioral disruption
- Have behavior that is not well controlled without constant adult supervision or use of psychotropic medication; basic structure and nurturance are not sufficient.

#### **D. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Staffing Pattern – This program will provide twenty-four (24) hour awake staffing **in** addition to the required staffing ratio outlined in Provider Policy Manual.
- Counseling – Services in the form of individual, group, or family counseling, case management and treatment planning must be provided.
- Educational Liaison – Children’s psychological functioning should allow educational needs to be met through the public schools of the community, **including** both general and special education programs. Staff person(s) must be identified as **a** liaison between the treatment program and the community-based educational system.
- Structured Treatment Activities – **This** involves structured group activities designed to encourage, direct, and instruct children in the acquisition of skills needed to develop self-sufficiency and personal competence, and prevent or reduce the need for institutionalized care. These activities should account for three (3) hours of daily treatment programs.
- Adjunct And Specialized Services – Specialized services should be obtained by utilizing community resources whenever possible. Certain therapeutic services above the basic core services may be necessary and must be provided by consultants and therapists to meet **the** special needs of children. Therapy services must be provided by appropriately licensed, certified or supervised professionals.

#### **E. DEFINITION OF SERVICES**

##### **1. Residential Level II**

This is a highly structured, group living program for children and adolescents with relatively moderate to serious emotional or behavioral problems in a community setting.

Some children in these programs attend regular or special education classes in public schools, but others may attend on-campus schools. Youth in this program may not have responded successfully to less intensive treatment, such as Level 1 Residential Care or Foster Care. These programs constitute therapeutic group homes in which the main mission is to provide treatment. Children and youth in these programs require residential settings designed to improve social, emotional, and educational adaptive behavior. Services provided to achieve these goals include: group, individual, and family counseling where appropriate, liaison services, provision of appropriate adult role models, and training in the areas of social, emotional, and cognitive skills.

## **F. INELIGIBLE CHILDREN**

Children who are considered ineligible for Level II programs are those who are autistic, actively psychotic, **or** diagnosed with moderate or more severe mental retardation, unless the program is designed to serve children with mental retardation, or **are** actively suicidal or homicidal. Youth who have displayed major acts of violence or aggression such as rape, unless the program is designed to serve sex offenders, arson, assault with a deadly weapon, murder, or attempted murder within the past six (6) months are ineligible for this level treatment program.

## **G. CASE RECORD**

Daily progress notes are required in the case record of each child. Progress notes must be based on the progress of the child and family in meeting treatment objectives, and should also include information on any significant incidents, home passes, and/or new treatment needs being evidenced by the child and/or family. Case recordings and all other documentation concerning contacts or developments in the cases of class members shall be added to the case file for that child within 30 days of the case work activity or development. The case files of class members shall contain adequate documentation tracking the services provided, progress, any change in placement of the child, and authorizations which document the approval for placements, treatment and services provided to each child. Documentation of program treatment with schedule for all residential programs must be included in the client file. A progress report/treatment summary on each child in the program must be provided to the DCS case manager and the DCS/CSA regional resource manager for review on at least a quarterly basis. The IPP/Treatment Plan must be reviewed and updated/modified whenever indicated, but at least quarterly. The plan and documentation must reference the child's permanent plan. All members of and participants in the treatment team must receive adequate notice of and be encouraged to attend such staffings. NOTE: All procedures must be carried out in compliance with the DCS Appeals Process.

## **H. STAFFING PATTERNS**

- 24 hour awake staff is required.

- 1:8 ratio; at night, at least one (1) awake staff person for each eight (8) children enrolled in the program.

## **I. TRANSITION**

A child may transition from a Residential program into a foster care program. This transition may last up to two (2) months per each foster home placement attempted. The Department of Children's Services Regional Administrator shall approve the transition plan. The Provider shall be paid for days of service the child visits the foster parents for up to a maximum of fifteen (15) days per foster home placement attempted in accordance with the approved plan. The foster parents may also be reimbursed for days of service when the child is with them.

## **XII. LEVEL II SPECIAL POPULATIONS**

### **A. PROGRAM DESCRIPTION**

Level II Residential Services is a structured group home, residential treatment facility, or Wilderness program which provides structure, counseling, behavioral intervention, and other needs identified in a child's permanency plan for youth with moderate clinical needs. The youth do not attend public school in the community for specified treatment reasons.

### **B. POPULATION SERVED**

This population meets the scope of services for Level II; however, due to current issues of alcohol and drug addiction, sexual offenses, or current temporary zero tolerance issues in education, youth must, for community safety and specific treatment issues listed above, attend an "in house" or non public school. The Resource Manager, in collaboration with the Home County Case Manager and Departmental Educational Specialist, must authorize any non public school placement for youth and admission to this contract type, as outlined in the Brian A. Educational Work Plan.

Children eligible for this level program must have a Diagnostic & Statistical Manual, Fourth Edition (DSM-IV) diagnosed mental illness or be identified by a mental health professional as having at least moderate emotional and/or behavioral problems and be in need of treatment. Children may also have Level II substance abuse needs or have had Level III substance abuse needs and have successfully completed an Alcohol and Drug Treatment Program. Children may be delinquent, chronic runaways, display manipulative behaviors, have difficulty maintaining self-control, display poor self-esteem, have difficulty in securing and maintaining close relationships with others, be habitually truant from school and have difficulty in accepting authority. Children with a history of sexual offenses are eligible if they have successfully completed a sex offender treatment program and/or have been deemed not to pose a serious risk by a recognized sex offender treatment professional.

These children have not responded successfully to less intensive interventions or have been denied admission or discharged from less intensive placements because of their emotional or behavioral problems. The behavior of these children is not well controlled without constant adult supervision. Some children may be in need of psychotropic medication.

The Level II Department of Children's Services (DCS) Provider must review any child with developmental delay referred on a case-by-case basis to determine if the child could be appropriately served. A diagnosis of mental retardation must not be used as a basis to refuse admission to a child when the child's behavioral issues fall within the program's Scope of Service. A diagnosis of mental retardation must be based on assessment of both

the child's intellectual and adaptive level of functioning. The assessment must be graded according to professionally accepted assessment instruments.

Children needing Level II services are basically healthy. Routine medical attention for minor health problems or for monitoring medication may be required.

Pregnant females admitted before the third trimester who have no major health problems, which would hinder participation, are also eligible.

At this level, children typically:

- Need clinical treatment in order to function in school, home, or the community because of multiple problems
- Have not responded successfully to less intensive treatment and/or have been denied admission or discharged from various placements because of emotional and behavioral disruption
- Have behavior that is not well controlled without constant adult supervision or use of psychotropic medication; basic structure and nurturance are not sufficient.

All Wilderness Programs are allowed to maintain groups of children within the program, ranging in size from eight (8) to twelve (12) children with a staffing ratio of 1:8. Awake staff at night will not be required per campsite, but two to three individuals who rotate through campsites (i.e. "rovers") will be required. One "rover" will be required for each two campsites in the Provider's program.

### **C. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Staffing Pattern - program will provide 24-hour awake staff in addition to the required staffing ratio outlined in Provider Policy Manual.
- Counseling - services in the form of individual, group, or family counseling, case management, and treatment planning be provided.
- Educational Services - children's psychological functioning is such that educational needs cannot be met through the public schools of the community. A staff person should act as liaison between the treatment program and the community-based educational system. Providers must have on-site educational programs which provide both general and special education programs which meet Department of Education and DCS' standards.
- Structured Treatment Activities - involves structured group activities designed to encourage, direct, and instruct children in the acquisition of skills needed to develop self-sufficiency and personal competence, and prevent or reduce the need for institutionalized care. These activities should account for three (3) hours of daily treatment programs.
- Adjunct and Specialized Services - specialized services should be obtained by utilizing community resources whenever possible. Certain therapeutic services above the basic core services may be necessary and must be provided by consultants and

therapists to meet special needs of children. Therapy services must be provided by appropriately licensed, certified or supervised professionals.

## **D. DEFINITIONS OF SERVICES**

### **1. Residential Level II**

This is a highly structured, group living program for children and adolescents with relatively moderate to serious emotional or behavioral problems in a community setting. Children in these programs attend on-campus schools due to treatment needs. Children in this program may not have responded successfully to less intensive treatment, such as Level I Residential Care or Foster Care. These programs constitute therapeutic group homes in which the main mission is to provide treatment. Children in these programs require residential settings designed to improve social, emotional, and educational adaptive behavior. Services provided to achieve these goals include: group, individual, and family counseling where appropriate, liaison services, provision of appropriate adult role models, and training in the areas of social, emotional, and cognitive skills. Children have a documented need for a self-contained educational program in order to meet their permanency and treatment goals.

### **2. Wilderness**

This service provides an outdoor therapeutic program, which uses community, experiential, and adventure based activities in a group milieu to actively involve youth in a process of developing personal strengths and solutions, which the youth utilize to satisfy their basic needs and effectively cope with the demands of daily living. Program objectives are to develop responsible attitudes, self-discipline, socially acceptable values, problem-solving skills, and empowerment using cognitive/behavioral approaches to develop responsible, moral changes in conduct-disordered children and adolescents. Ineligible youth for this program are those with a history of fire setting. Youth with serious physical handicaps/limitations that would be exacerbated by wilderness activities or a wilderness environment including serious respiratory problems not controlled by medication, chronic musculoskeletal disorders and other conditions requiring constant medical attention that cannot be dealt with in a wilderness setting are not eligible for this program.

### **3. Residential Level II Alcohol & Drug**

This type of program provides therapeutic services to youth who have either repeatedly abused or have become dependent on alcohol and/or other drugs whose placement in state custody. Children with a history of sex offenses are eligible if they have successfully completed a sex offender program and/or have been deemed not to pose a serious risk by a recognized sex offender treatment professional. These youth may have emotional and/or behavioral problems in conjunction with their chemical dependency. Treatment is provided in a staff secure, self-contained, intensive residential treatment rehabilitation program for youth who are not well controlled without constant adult supervision and pose a significant risk to the community. The structured program is directed toward the reduction or elimination of the youth's chemical dependency while promoting the development of an addiction-free lifestyle.

Services may include: group, individual, and family counseling (where appropriate), liaison services, provision of appropriate adult role models, and training in the areas of social, emotional, and cognitive skills. Children in these programs may attend regular or special education classes in public schools. In-house schools must meet Department of Education guidelines and be approved for both regular and special education services.

#### **E. INELIGIBLE CHILDREN**

Children who are considered ineligible for Level II programs are those who are autistic, actively psychotic, diagnosed with moderate or more severe mental retardation (unless the program is designed to serve children with mental retardation), or actively suicidal or homicidal. Youth who have displayed major acts of violence or aggression such as rape (unless the program is designed to serve sex offenders), arson, assault with a deadly weapon, murder, or attempted murder within the past six (6) months are ineligible for this level treatment program.

### **XIII. LEVEL II SPECIAL NEEDS**

#### **A. PROGRAM DESCRIPTION**

Level II Residential Services is a structured group home or residential treatment facility specializing in treatment of youth with both developmental delays and behavioral and/or emotional disorders. The program provides structure, counseling, behavioral intervention, and other needs identified in a child's permanency plan. Children and youth may, if appropriate, attend an on-site school approved by the Department of Education and the Department of Children's Services Educational Division.

#### **B. POPULATION SERVED**

Children eligible for this level program must have a Diagnostic & Statistical Manual, Fourth Edition (DSM-IV) diagnosed mental illness or be identified by a mental health professional as having at least moderate emotional and/or behavioral problems and be in need of treatment. Children also have a diagnosis of a development delay. Children may also have Level II substance abuse needs or have had Level III substance abuse needs and have successfully completed an Alcohol and Drug Treatment Program. Children may be delinquent, be chronic runaways, display manipulative behaviors, have difficulty maintaining self-control, display poor self-esteem, have difficulty in securing and maintaining close relationships with others, be habitually truant from school and have difficulty in accepting authority. Children with a history of sexual offenses are eligible if they have successfully completed a sex offender treatment program and/or have been deemed not to pose a serious risk by a recognized sex offender treatment professional.

These children have not responded successfully to less intensive interventions, or have been denied admission, or discharged from less intensive placements because of their emotional or behavioral problems. The behavior of these children is not well controlled without constant adult supervision. Some children may be in need of psychotropic medication.

Additionally, this population may require more intensive structure and interventions and it may be necessary for the Provider to provide more individualized training and services to meet the needs of the child.

#### **C. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Staffing Pattern - program should provide twenty-four (24) hour awake staff with staffing ratio as outlined in the provider policy manual
- Counseling - individual, group, or family counseling
- Case management, and treatment planning

- Educational - children's psychological functioning is such that educational needs may not be met through the public schools of the community. Youth who attend a campus based educational program must be reviewed and a treatment team must determine that the campus school is essential for the treatment coordination of the child. A staff person must act as liaison between the treatment program and the community-based educational system. Providers with on-site educational program will provide both general and special education programs which meet Department of Education and DCS' standards for children who do not attend local public school.
- Structured Treatment - activities involving structured group activities designed to encourage, direct, and instruct children in the acquisition of skills needed to develop self-sufficiency and personal competence, and prevent or reduce the need for institutionalized care. These activities should comprise three (3) hours of daily treatment programs.
- Adjunct and Specialized Services - specialized services should be obtained by utilizing community resources whenever possible. Certain therapeutic services above the basic core services may be necessary, and must be provided by consultants and therapists, to meet special needs of children. Therapy services must be provided by appropriately licensed, certified or supervised professionals.

#### **D. DEFINITIONS OF SERVICES**

##### **1. Residential Level II Sex Offender Dual Diagnosis**

This program provides services for children and youth found to have a history of sex offenses who have also been diagnosed as having a serious emotional and/or behavioral disorder.

##### **2. Residential Level II Mental Retardation Dual Diagnosis**

Children eligible must have a DSM-IV axis II diagnosis of moderate to mild mental retardation (IQ range 35-70). Secondary handicapping condition can be an Axis I diagnosis. Children eligible may be identified by a mental health professional as having at least moderate emotional and/or behavior problems and be in need of treatment. Children admitted are appropriate for community based treatment and do not pose significant risk to the community or others.

#### **E. INELIGIBLE CHILDREN**

Children who are considered ineligible for Level II programs are those who are autistic, actively psychotic, diagnosed with moderate or more severe mental retardation, unless the program is designed to serve children with mental retardation, or actively suicidal or homicidal. Youth who have displayed major acts of violence or aggression such as rape, unless the program is designed to serve sex offenders, arson, assault with a deadly weapon, murder, or attempted murder within the past six (6) months are ineligible for this level treatment program.

## **XIV. LEVEL III RESIDENTIAL PROGRAM**

### **A. CHARACTERISTICS**

- High intensity treatment programs
- High security/high supervision

### **B. PROGRAM DESCRIPTION**

Level III Residential Services is a structured residential treatment facility which provides structure, individual and group therapy, behavioral intervention, and other needs identified in a child's permanency plan for youth with serious clinical needs. Youth's needs include intensive day treatment programming.

### **C. POPULATION SERVED**

Children eligible for this program level must have a Diagnostic & Statistical Manual, Fourth Edition (DSM-IV) diagnostic mental illness or be identified by a mental health professional as having serious emotional and/or behavioral problems and be in need of treatment. These problems must pose a severe level of impairment to overall **serious dysfunction** in multiple areas.

These children may be delinquent, chronic runaways, display manipulative behaviors, have difficulty maintaining self-control, display poor self-esteem, and have difficulty in accepting authority. Children with significant substance abuse needs, which require intensive treatment, are also eligible. These children may be diagnosed as autistic or display autistic-like behaviors.

This population may exhibit significant disruptive behaviors such as persistent or unpredictable aggression, and moderate to serious risk of causing harm to themselves or others.

These children have not responded successfully to less intensive interventions, or have been denied admission or **been** discharged from various placements because of their emotional and behavioral problems. There is a need for constant adult supervision and intense treatment, which could include the use of psychotropic medication. This is a population at high risk of hospitalization or institutionalization because of the pervasive nature of their problems.

Although usually in good health, these children may require medical attention for health problems or for monitoring medications. Ineligible children are actively homicidal, actively suicidal, or those children who have a psychosis not controlled with medication. Youth who have displayed major acts of violence or aggression such as rape, arson, assault with deadly weapon, murder, and attempted murder within the past six (6) months are also ineligible for the program.

**The scope of service does not require serving children with a diagnosis of mental retardation (IQ of 70 or below based on assessment of both a child's intellectual and adaptive level of functioning, according to professionally accepted assessment**

instruments) unless the program is designed to serve this population. However, the provider must review any such child referred on a case-by-case basis to determine if the child could be appropriately served.

#### **D. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Staffing Pattern - program must provide twenty-four (24) hour awake staff as outlined in Provider Policy Manual,
- Therapy - requires that direct services in the form of individual, group, or family therapy, case management, and treatment planning be provided. Therapy services must be provided by appropriately licensed, certified or supervised professionals;
- Educational Services - the level of treatment intervention needed to manage the emotional/behavioral problems of these children may involve a self-contained day school program designed to provide instruction. Testing, assessments, and educational planning to address the special needs of residents must be available. (This includes vocational training.) Educational staff must include certified special education teachers and teacher aides. Providers with on-site educational services must be approved by the Department of Education (DOE) and monitored according to a monitoring cycle established by DOE. Schools must also be approved by DCS Educational division
- Structured Treatment Activities - involves structured group activity to encourage, direct, and instruct children in the acquisition of skills needed to develop self-sufficiency, personal competency, and prevent or reduce the need for institutionalized care. These activities should account for four (4) hours of daily treatment program.
- Adjunct and Specialized Services - specialized services such as recreation, recreational therapy, expressive therapy, psychological and psychiatric services, should be provided by therapists and consultants, as needed, to develop and maintain a comprehensive services program.
- School Liaison Services - services which support youth transitioning to local public educational programs, either upon discharge, or as appropriate while in the agency
- Level 3 Residential Treatment - services in a structured residential treatment facility which provides intensive family, individual and group therapy, behavioral intervention, and other needs identified in a child's permanency plan for youth with serious clinical needs. Youth's needs include intensive day treatment programming.

#### **E. DEFINITIONS OF SERVICES**

##### **1. Level 3 Alcohol and Drug Treatment**

This program provides an intensive, highly structured staff-secure residential treatment program for children and youth with diagnosed alcohol and drug treatment issues. Some

of these youth may have completed a more intense program of assessment and begun the initial phase of treatment, but are still in need of intensive residential treatment. These children and youth may or may not have been found delinquent because of their offenses. Intensive intervention by licensed and/or certified clinicians, focusing on substance abuse recovery is provided.

## **2. Level 3 Dual Diagnosis**

This program provides intensive treatment services for youth with dual diagnosis of mental retardation and psychiatric disorders within Level III Scope of Services.

## **3. Level 3 Sex Offender**

This program provides an intensive, highly structured staff-secure residential treatment program for children and youth who have committed sexual offenses. Some of these youth may have completed a more intense program of assessment and begun the initial phase of treatment, but are still in need of intensive residential treatment. For others, this program will be their initial entry into treatment for sexual offenses. These children and youth may or may not have been found delinquent because of their offenses. The serious nature of the offenses requires that the youth have constant adult supervision due to the continued significant risk they pose to others and the community.

## **F. INELIGIBLE CHILDREN**

Ineligible children are those who are diagnosed mentally retarded (unless the program is designed to serve children with mental retardation), actively homicidal, actively suicidal, and/or those children who have a psychosis not controlled with medication. Children who require chemical or mechanical restraints for severe agitation or aggression are ineligible to the program. Youth who constantly display assaultive or combative behaviors (e.g., routinely assaulting other children and adults with weapons), those who consistently demonstrate self-injurious behaviors which may result in a fatal injury, those with complex medical conditions requiring isolation, those displaying predatory or aggressive sexual behaviors, children who have displayed major acts of violence or aggression such as rape (unless the program is designed to serve sex offenders), and children who have displayed behaviors such as arson, assault with a deadly weapon, murder, and attempted murder within the past six (6) months are also ineligible for admission.

## **G. CASE RECORD**

Daily progress notes are required in the case record of each child. Progress notes must be based on the progress of the child and family in meeting identified treatment objectives, and should also include information on any significant incidents, home passes, and/or new treatment needs evidenced by the child and/or family. Case recordings and all other documentation concerning contacts or developments in the cases of class members shall be added to the case file for that child within 30 days of the case work activity or development. The case files of class members shall contain adequate documentation

tracking the services provided, progress, any change in placement of the child, and authorizations which document the approval for placements, treatment and services provided to each child. Documentation of milieu treatment with schedule for all residential programs must be included in the client file. A monthly progress summary/treatment report on each child in the program must be provided to the DCS case manager and DCS/CSA regional resource manager for review. The IPP/Treatment Plan must be reviewed and updated/modified whenever indicated, but at least quarterly.

## **H. STAFFING PATTERNS**

- 24 hour awake staff is required.
- 1:5 ratio during awake hours; at night, at least one (1) awake staff person for each eight (8) children enrolled in the program.

## **I. TRANSITION**

A child may transition from a Residential program into a foster care program. This transition may last up to two (2) months per each foster home placement attempted. The Department of Children's Services Regional Administrator shall approve the transition plan. The Provider shall be paid for days of service the child visits the foster parents for up to a maximum of fifteen (15) days per foster home placement attempted in accordance with the approved plan. The foster parents may also be reimbursed for days of service when the child is with them.

## **XV. LEVEL III HARDWARE SECURE PROGRAM**

### **A. PROGRAM DESCRIPTION**

Level III Residential Services is a structured residential treatment facility which provides structure, individual and group therapy, behavioral intervention, and other needs identified in a child's permanency plan for youth with serious clinical needs. Youth's needs include intensive day treatment programming.

### **B. POPULATION SERVED**

Children eligible for this program level must have a Diagnostic & Statistical Manual, Fourth Edition (DSM-IV) diagnostic mental illness or be identified by a mental health professional as having serious emotional and/or behavioral problems and be in need of treatment. These problems must pose a severe level of impairment to overall functioning in multiple areas.

These children may be delinquent, chronic runaways, display manipulative behaviors, have difficulty maintaining self-control, display poor self-esteem, and have difficulty in accepting authority. Children with significant substance abuse needs which require intensive treatment are also eligible. These children may be diagnosed as autistic or display autistic-like behaviors.

This population may exhibit significant disruptive behaviors such as persistent or unpredictable aggression, and moderate to serious risk of causing harm to themselves or others.

These children have not responded successfully to less intensive interventions, or have been denied admission or discharged from various placements because of their emotional and behavioral problems. There is a need for constant adult supervision and intense treatment, which may include the use of psychotropic medication. This is a population at high risk of hospitalization or institutionalization because of the pervasive nature of their problems.

Delinquent adolescents and/or children with a history of untreated sexual offenses may require that services be provided in a secure setting due to the potential risk they pose to the community. The Provider, whose scope of services does not require serving children with mental retardation, must review any such child referred on a case-by-case basis to determine if the child could be appropriately served. A diagnosis of mental retardation must not be used as a basis to refuse admission of a child when the child's behavioral issues fall within the program's Scope of Service. A diagnosis of mental retardation must be based on an assessment of both a child's intellectual and adaptive level of functioning according to professionally accepted assessment instruments.

Although usually in good health, these children may require medical attention for health problems or for monitoring of required medications. Ineligible children are those who are diagnosed as moderate to severe mentally retarded or (unless the program is designed to serve children with mental retardation), actively homicidal, actively suicidal, or those children who have a psychosis not **currently** controlled with medication. Youth who have displayed major acts of violence or aggression such as rape (unless the program is designed to serve sex offenders), arson, assault with deadly weapon, murder, and attempted murder within the past six (6) months are also ineligible for the program.

### **C. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Staffing Pattern - program should provide twenty-four (24) hour awake staff in addition to the required staffing ratio outlined in Provider Policy Manual.
- Therapy - requires that direct services in the form of individual, group, or family therapy, case management, and treatment planning be provided. Therapy services must be provided by appropriately licensed, certified or supervised professionals.
- Educational Services - The level of treatment intervention needed to manage the emotional/behavioral problems of these children may involve a self-contained day school program designed to provide instruction. Testing, assessments, and educational planning to address the special needs of residents must be available. (this includes vocational training). Educational staff must include certified special education teachers and teacher aides. Providers with on-site educational services will be monitored by the Department of Education (DOE) according to a monitoring cycle established by the DOE.
- Structured Treatment Activities - involves structured group activity to encourage, direct, and instruct children in the acquisition of skills needed to develop self-sufficiency, personal competency, and prevent or reduce the need for institutional care. These activities should account for four (4) hours of daily treatment program.
- Adjunct and Specialized Services - specialized services such as recreation, recreational therapy, expressive therapy, psychological and psychiatric services, should be provided by therapists and consultants, as needed, to develop and maintain a comprehensive services program.

### **D. DEFINITIONS OF SERVICES**

#### **1. Residential Level III Hardware Secure**

Eligible population for placement - The eligible population shall, at a minimum, have the following:

- A diagnosis made by a physician or psychologist licensed as a health service provider of a mental illness or serious emotional or behavioral disturbance and be recommended for a hardware secure residential treatment setting;

- Past or present charges of delinquency which may include the most serious violent felonies against persons, and **be in custody of the** Department of Children's Services (DCS)/Juvenile Justice;
  - DCS staff will provide a referral packet for the agency and following review **of the information, the** youth meeting the eligibility criteria as described in the contract shall be admitted.
2. Youth shall not be terminated without the agreement of DCS central office coordinating staff person.
  3. The Provider shall provide, or obtain through other appropriate sources at no additional cost to the state, the following services for youth admitted to the program:
    - Therapeutic environment twenty-four (24) hours per day, including appropriate and safe physical shelter, supervision and food
    - Hardware security with appropriate plant equipment and staffing patterns for the safety of youth and staff
    - Individual treatment plan
    - Identified problems are addressed
    - Individual treatment plans shall be initiated upon admission and completed within fourteen (14) days of admission
    - The clinical director and treatment team shall review plans monthly, or more often, as indicated. All reviews will be summarized and made available to the State upon request
    - Plans shall be reviewed quarterly based upon the admission date. The Provider will provide the custody department with seven (7) days notice when scheduling such reviews to allow the State to participate. The State shall be provided a copy of each quarterly review summary
    - The parents or guardians and custody department shall be invited and encouraged to attend the initial planning and all major reviews of the plan or any special staffing which significantly changes the plan
    - Family interventions shall be provided as indicated in the treatment plan
    - Each youth shall receive no less than one hour per week of individual psychotherapy provided by a psychologist licensed by the State of Tennessee as a Health Service Provider, and
    - Each youth shall receive no less than two (2) hours per week of group therapy provided by a master's level licensed social worker or other licensed Clinical Services Provider.

#### **E. INELIGIBLE CHILDREN**

- Any youth in need of alcohol and drug detoxification, and/or
- Youth committable to an acute psychiatric hospital under state statute.

## **F. DISCHARGE AND AFTERCARE SERVICES**

The Provider shall give the custody department seven (7) days notice of the final treatment review staffing where discharge planning is to take place so that the State may participate in the staffing.

The Provider shall not discharge or release any youth without formal approval from the custody department.

The Provider shall provide the custody department with a complete discharge summary of program progress and recommendations at the time for the youth's discharge date.

## **G. ADDITIONAL REQUIREMENTS**

- Psychotropic Medication - medication shall be prescribed and monitored by a board eligible or board certified psychiatrist. Informed consent shall be obtained from the student's parents or legal guardian prior to administering any psychotropic medication. A record of the consent and medication administration records shall be a part of the student's file and available to the State for review.
- Incidents and Special Notification of Custody Department - the Provider shall notify and consult with the custody department in a timely fashion in response to all of the following special circumstances and be in compliance with the DCS Incident Reporting Manual.
- Court Liaison - although the custody department shall be responsible for all contacts with the committing court, the Provider shall assist the State by providing requested information and progress reports. The custody department shall keep the Provider informed of the youth's legal status and of pending court reviews or hearings which may affect the youth's legal status.
- Outcome Measures - eighty-five percent of residents shall complete treatment and move to less restrictive settings. Exceptions to less restrictive setting placements shall be residents who must return to the Department of Children's Services Youth Development Centers.

## **XVI. CONTINUUM OF CARE PROGRAMS - GENERAL**

### **A. GENERAL DESCRIPTION**

Continuum of Care is a model of care that focuses on providing treatment in a flexible manner, facilitating permanence. Continuums allow the Provider greater flexibility in designing services for family, child, and to promote permanency in a timely way. Continuums include an array of services including residential, foster care, in-home services and the capability to obtain or provide the services needed by child and family.

## **XVII. LEVEL II CONTINUUM**

### **A. PROGRAM DESCRIPTION**

Continuum of Care is a service-based model of care which purchases the outcome of successful permanency for children. Continuums have greater flexibility in designing services for the child and family, the ability to facilitate more rapid movement of the child to permanency and the ability to customize the delivery of services to each child and family in the least restrictive and cost effective manner. Programs must meet the staffing patterns outlined in each level of care in the policy manual

### **B. POPULATION SERVED**

Children eligible for this level program must have a Diagnostic & Statistical Manual, Fourth Edition (DSM-IV) diagnostic mental illness or be identified by a mental health professional as having at least moderate emotional and/or behavioral problems and be in need of treatment. Children may also have Level II substance abuse needs or have had Level III substance abuse needs and have successfully completed an Alcohol and Drug Treatment Program. Children may be delinquent, chronic runaways, display manipulative behaviors, have difficulty maintaining self-control, display poor self-esteem, have difficulty in securing and maintaining close relationships with others, be habitually truant from school and have difficulty in accepting authority. Children with a history of sexual offenses are eligible if they have successfully completed a sex offender treatment program and/or have been deemed not to pose a serious risk by a recognized sex offender treatment professional.

These children have not responded successfully to less intensive interventions or have been denied admission or discharged from less intensive placements because of their emotional or behavioral problems. The behavior of these children is not well controlled without constant adult supervision. Some children may be in need of psychotropic medication.

The Level II Department of Children's Services (DCS) Provider, must review youth with developmental delays on a case-by-case basis to determine if the child could be appropriately served. A diagnosis of mental retardation must not be used as a basis to refuse admission to a child when the child's behavioral issues fall within the program's Scope of Service. A diagnosis of mental retardation must be based on assessment of both the child's intellectual and adaptive level of functioning. The assessment must be graded according to professionally accepted assessment instruments.

Children needing Level II services are basically healthy. Routine medical attention for minor health problems or for monitoring medication may be required.

At this level, children typically:

- Have need of clinical treatment to be able to function in school, home, or the community because of multiple problems;
- Have not responded successfully to less intensive treatment and/or have been denied admission or discharged from various placements because of emotional and behavioral disruption;
- Have behavior that is not well controlled without constant adult supervision or use of psychotropic medication; basic structure and nurturance are not sufficient.

Children who are considered ineligible for Level II programs are those who are autistic, actively psychotic, diagnosed with moderate or more severe mental retardation, unless the program is designed to serve children with mental retardation, or actively suicidal or homicidal. Youth who have displayed major acts of violence or aggression such as rape, unless the program is designed to serve sex offenders, arson, assault with a deadly weapon, murder, or attempted murder within the past six (6) months are ineligible for this level treatment program.

Children enter a continuum program at a specified level of service, i.e. Level II. The Provider is then responsible for providing or coordinating all services needed by the child and family, progressing the child through to less restrictive and more home/community based placements/services as soon as possible.

Continuum of Care is a service-based model of care, with a focus on permanency and involvement of all individuals identified on the child's permanency plan. Continuums must admit, on a monthly basis, a minimum number of children, which is in each contract.

In addition to residential treatment, group care, and foster care, continuums provide home/community-based services, which will facilitate successful reunification of the child with the family. Continuums ensure 80% success in reunification or other permanency arrangements for children served by the program. Success within the continuum is defined as the outcome of the child being maintained with family, adoption, relative, independent living or final permanency plan goal for nine (9) consecutive months.

Appropriate court and D.C.S. approvals must be obtained prior to returning children to the home or allowing children to remain in-home for treatment. In all cases, the Department of Children's Services case manager and all involved adults identified in the permanency plan must receive verbal or written notification prior to a child being moved within the continuum.

The Provider, in conjunction with the DCS case manager, family, involved adults, and child shall design and implement an individualized treatment plan based on the unique needs of each child and family as identified by the DCS case manager. The Provider's individualized treatment plan will follow and enhance the State's Permanency Plan of Care developed by the State's case managers.

Monthly progress reports and treatment summaries shall be completed for each child enrolled in the continuum program. Such reports shall be forwarded to the DCS case manager for review.

Services must be provided as outlined in each youth's Plan of Care through Providers qualified as outlined in the Provider Policy Manual. These services are defined as follows:

- Counseling - direct services in the form of individual, group, or family counseling, which address behavioral or mental health needs impairing social, educational, or psychological functioning. For programs specifically serving sex offenders, counseling should address sexual perpetration issues in addition to meeting other counseling needs.
- Educational Services - children's educational needs must be met through the least restrictive environment appropriate to meet the educational needs of the child. This includes both general and special education programs. Some youth may also need special day school programs, due to treatment needs. A staff person must act as liaison between the treatment program and the community based educational system. On-site educational programs will provide both general and special education programs for children who do not attend local public schools.
- Structured Treatment Activities - involves structured group activities designed to encourage, direct, and instruct children in the acquisition of skills needed to develop self-sufficiency and personal competence, and prevent or reduce the need for institutionalized care. These activities should account for three (3) hours of daily programs in group and residential treatment.
- Adjunct and Specialized Services - specialized services should be obtained by utilizing community resources whenever possible. Some support or therapeutic services above the basic core services, such as sexual abuse counseling or substance abuse intervention, may be necessary and must be provided by consultants or therapists to meet special needs of children. Appropriately licensed certified or supervised professionals must provide therapy services.
- Case Management – case coordination services provided by an individual, who at a minimum, has a bachelor's degree in one of the social sciences. Case management includes developing the Family Service Plan, monitoring implementation of the plan, and locating all services and placements a child and/or family may need while enrolled in the continuum. It also includes documenting progress, problems, maintaining contacts with the custody department and Resource Managers, revising the Family Service Plan, as needed, maintaining ongoing contacts with the child and/or family, planning and implementing the progression of a child/family through the continuum, aftercare planning, and monitoring of aftercare services.

Services provided to children and families in any level of the continuum either directly by the provider or coordinated by the provider include, but are not limited to the following, as determined by the treatment or permanency plan:

- Individual, Group, Family, Marriage and/or Multi-Family Counseling;

- Parenting Skills – individualized coaching and training to assist parents with issues related to discipline, child development, child-rearing skills, and behavioral intervention
- Sexual Abuse Counseling and Sexual Perpetration Counseling – counseling and intervention services to address issues related to sexual abuse and sexually reactive behaviors;
- Substance Abuse Counseling – counseling and intervention services targeting issues related to alcohol and/or drug misuse;
- Emergency Placement Services – services available 24 hours a day through on-call system which stabilize children and families by locating alternative short term placement
- Specialized Educational Services - services which supplement specialized services being provided by the local school system or Provider's in-house school;
- Vocational Assessments/Services/Planning/Training - vocational aptitude and interest surveys must be administered by properly trained and/or licensed professionals. Vocational training or services may be accomplished through enrolling the child in accredited vocational training courses or approved apprenticeships;
- Job Placement Assistance - assistance provided by the Provider, contracted staff, certified guidance counselor, school system, or other approved entity, in helping a child find appropriate part or full time employment;
- Independent Living Education/Arrangements - this service is defined as enrolling the child in an appropriately licensed independent living program, or providing supervision and support services to a child in a residential placement which the Provider has helped to locate and secure; case management and planning by a person possessing, at a minimum, a bachelor's degree in one of the social sciences;
- Dietetic and Nutrition Services - services of one hour or more in duration which are provided, at a minimum, by a certified dietitian, medical doctor, or licensed registered nurse;
- Medical and Nursing Services - services provided by a licensed physician, or licensed registered nurse, of the type and duration indicated by documented medical need;
- Crisis Intervention/Stabilization - services provided on a twenty-four (24) hour basis to a child and/or family experiencing a medical, mental health, parent/child interaction, or other significant emergency need. Services must, at a minimum, be provided by an individual with a bachelor's degree in one of the social sciences and who has access to licensed professionals possessing, at a minimum, a Master's degree in one of the behavioral sciences;
- Community Support Services - a variety of support services provided to the family in the home; must not include support services funded by the State under separate contractual arrangements;
- Mental Retardation Services - specialized services designed to address the developmental deficits and skills development needs of individuals with validated diagnoses of mental retardation;

- Family Planning Assistance - education and guidance provided to a child and/or family regarding planning/preventing child birth; may include alternatives available for pregnant teens;
- Respite - services to provide agency foster parents or family for appropriate periods of breaks in care with child returning to the caregiver;
- Adoption Assistance Services - services designed to assist in locating and placing eligible children in adoptive homes.
- Home-Based Treatment - an array of services, which may be provided to a family to keep the family intact or ensure successful reunification.

Home-based treatment services provided within the continuum must address the systematic factors contributing to the problems of children and families. Treatment must be family-focused and address reunification issues, as indicated in the treatment and/or permanency plan. Services include, but are not limited to the array of services coordinated or provided by the continuum.

Home-based treatment services are intensive treatment case-management and support services provided to the child and family to keep the family intact or to ensure successful reunification. Home-based services are not to be construed as after care services.

Home-based treatment services assist the family and child to remain together rather than placement in psychiatric hospitals, residential programs, or foster care.

Home-based treatment services must be designed to reduce the length of stay for children currently in residential programs, therapeutic foster care, and psychiatric hospitals, providing them with a successful transition home. Additionally, they should provide or coordinate comprehensive mental health treatment and social support services to the entire family in the home. Home-based services should identify family members, friends, and other members of the community who are willing to have the child live in their homes or otherwise serve as family support.

**Minimum Standards for Home based treatment services must consist of the following:**

- Family Service agreement with treatment plan and staffing. The Staffing must include all team members;
- Home-based service workers must have a minimum of a Bachelor's degree in the social sciences or related field and at least one year of pertinent work experience preferably having been in a residential setting and supervisory experience being desirable, or, a Master's Degree;
- Home based services will have Staff dedicated and trained to a reorganized home base treatment model with documentation of training. Staffing ratio will be no more than one staff to ten (10) families, with fluctuation allowed, based on the levels of intervention needed;
- Twenty-four (24) hour on call crisis services with a plan to access face-to-face services within no more than two (2) hours;

- Intensive in-home services will require at least two (2) contacts weekly with a minimum of one (1) time weekly face-to-face contact with primary caretaker and child;
- Assessment/treatment plan, progress notes, monthly progress reports will address family, safety, education, peers and continuing needs. These reports will be submitted to the Residential Case manager, DCS Case managers and the Resource managers monthly;
- Quarterly staffing with all active participants will occur;
- Respite services will be available to meet treatment and safety needs.

Community based services provided by the Provider or other contracted Provider in-home based treatment, must not include services which are already funded by the state under separate contractual arrangements.

The frequency and intensity of interventions shall vary as the child and family progress through the continuum. All services provided are to be culturally competent, recognizing the cultural and ethnic heritage of children and families being served.

Each child admitted into the continuum shall have identified specific milestones for the child and family to reach in order to progress through various levels of the continuum. Step down to lower intensity must be fully documented through a staffing process, which is documented in the I.P.P. (individualized treatment plan) and includes all involved adults and age appropriate children.

Participation from the family in treatment planning shall be actively encouraged.

The Provider shall have the responsibility of determining, with input from home county, involved adults, and child, when each child/family is ready for movement through the continuum and the appropriate subsequent levels of care or services required following TennCare appeals and notice guidelines. DCS case manager should be an active participant in these decisions and shall be notified prior to the movement of the child/family within the continuum.

Written approval of DCS case manager, Child Abuse Review Team (CART), and the court must be obtained in child protective services (CPS) cases in which the department has petitioned for custody of the child if the child is to be allowed unsupervised visits with the persons alleged to have been responsible for the abuse or neglect of the child.

Written approval of DCS case manager, CART, and the court must also be obtained prior to the reunification of a CPS child with individuals who were deemed to have been responsible for the abuse/neglect and subsequent removal of the child from the home.

### **C. ALLOWANCES**

Allowances, as specified in the “General Requirements” section of the Provider Manual, are required for children enrolled in residential components of the continuum.

Allowances may be given to children, at the discretion of the Continuum Provider, after a child is returned home or other permanency arrangements are made.

#### **D. OUTCOME RESEARCH/IDENTIFIED SUCCESS CRITERIA**

All children discharged from the Continuum shall become part of the Provider's outcome evaluation and aftercare program. Discharge (D/C) occurs when the child and family are no longer receiving reimbursable continuum services. After care services are follow up services provided post D/C (after billing stops) to monitor a child and families progress and where possible support permanency after care is a non-billable service. This outcome evaluation and aftercare program shall consist of the following:

- Assessments of family and individual functioning at admission and discharge to a permanent placement;
- Monthly phone contact post discharge at 1, 2, 3 and 6 months;
- Phone contact will assess safety, education, peer relations, individual needs, medication and family community areas on discharge plan;
- Periodic evaluation of youth placement and families' activities at 3, 9, and 12 months;
- Post discharge to a permanent placement;
- Twenty-four (24) hour on call support, referral or other services will be provided at the discretion of the Provider.

Outcome indicators shall include:

- Placement status at discharge and at each evaluation point;
- Assessment of functional living skills (e.g. ability to function in school environment, etc.);
- History of legal system involvement;
- Use of mental health services;
- History of out-of-home placements;
- Analysis and outcomes shall include comparison of length of stay averages and service utilization with specific measures of individual and family functioning.

The Provider shall, at the request and direction of the State, conduct additional research and provide information relative to the Continuum of Care Services Model.

On a monthly basis, the Provider shall submit to the Division of Quality Assurance reports that include the following information:

- The number of new children and families entering the continuum on a monthly basis;
- The number of children and families served monthly;
- The number of children and families served year to date;
- The average length of stay for children and families currently in the continuum;
- Outcomes statistics as indicated in the contract;
- Other pertinent issues related to the service delivery system.

“Program success” is defined by the State as having an identified success rate in the numbers of children who are successfully maintained in their homes or other permanent placement for at least nine (9) consecutive months following placement. For children free for adoption and placed for adoption, nine consecutive months in the adoptive home is the continuum measure for success. The nine-month period for children reunified with their families begins at the time of physical placement back in the home. For children being adopted, the nine-month required period begins when the adoptive home agreement is signed.

Children who have not completed the continuum program (e.g. have not completed nine consecutive months of successful reunification with their families or nine consecutive months of successful placement in alternative “permanent” living arrangements), *and* who are requested by the Provider to be removed from the program, shall be considered and counted as “program failures”.

Children who run away from the program, shall be considered and counted as program failures only if they have been in the continuum for at least three (3) consecutive months and, remain on runaway status for more than ten (10) days, or are apprehended prior to ten (10) days but are not accepted back into the continuum. The Provider shall be construed to have refused to accept a child back into the continuum if the Provider refuses to admit the child into a program operated/contracted by the Provider, and/or refuses to provide services to the child and family at any level within the continuum.

## **E. DISCHARGES**

The Continuum of Care Services Model is designed to implement a variety of services based on the varying needs of children and families, it is expected that discharge of a child, prior to completion of the program, will not be requested.

The Provider shall not request the removal of a child from the program for such reasons as non-compliance with house rules, reported lack of “motivation”, or lack of progress in the program.

The Provider may request removal of a child from the continuum program if the child has validated, diagnosed, or adjudicated behaviors, which would place him in the category of children who are not eligible for admission to the program. The Provider shall be expected to exhaust all available means of service intervention prior to requesting such discharges.

De-authorizations may occur if appropriate services are not being provided.

De-authorization should be a consensus decision between the Provider, family and involved adults, age appropriate children, DCS case manager and resource manager. If this is not the case, an appeal should be filed, or mediation steps should be taken.

The Provider shall adhere to all State approved guidelines for staffing and discharge planning prior to any child's removal from the program.

Children who fail to complete at least nine (9) consecutive months of successful reunification in their "permanent" placement (e.g. home of parent or guardian, home of relatives, adoptive home, or permanent foster home) shall be provided with a revised Family Service Plan and shall be served by the continuum model at no additional cost to the State or such cases shall be determined "program failures" and be counted against the Provider's maximum allowable failure rate.

Children who are successfully or unsuccessfully discharged from the Continuum Program and who are no longer receiving services from the Provider may be referred again to the Provider for enrollment in the continuum program through the regular referral process. However, these youth must be prioritized on the regional resource management system's waiting list and an appropriate opening must be available in the Provider's continuum.

The Provider shall be responsible for the provision of appropriate services to children placed in detention. In such cases, the child and family shall be provided with a revised Family Service Plan and the child shall be returned to an appropriate level within the continuum following release from detention.

The Provider shall seek payment for required psychiatric hospitalization through the Behavioral Health Organization (BHO) to which the child is assigned or through the private insurance maintained by the child's family. If the appropriate certifications are not obtained, and/or the BHO or family's private insurance declines to pay the cost of psychiatric hospitalization, the cost shall be borne by the Provider.

## **XVIII. LEVEL III CONTINUUM**

### **A. PROGRAM DESCRIPTION**

Continuum of Care is a service-based model of care which purchases the outcome of successful permanency for children. Continuums have greater flexibility in designing services for the child and family, the ability to facilitate more rapid movement of the child to permanency and the ability to customize the delivery of services to each child and family in the least restrictive and cost effective manner. Staffing and other standards for each level of care must be met, as outlined in other sections of this policy manual.

### **B. POPULATION SERVED**

Children referred for admission to the Provider's program at the Level III point of entry will have a Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) clinical diagnosis of a mental disorder or will have been identified by a mental health professional as having serious emotional and/or behavioral problems and be in need of treatment at this level. Additionally, the child's family or primary caretaker(s) may be displaying a dysfunctional pattern of interaction or be exhibiting severe problem behaviors. These problems must pose a severe level of impairment to overall functioning in multiple areas.

These children may exhibit delinquent, chronic runaway, or manipulative behaviors. They may have difficulty maintaining self-control, display poor self-esteem, and have difficulty accepting authority. This population may exhibit significant disruptive behaviors such as persistent or unpredictable aggression, and be at moderate to serious risk of causing harm to themselves or others.

These children may be diagnosed as autistic, or display autistic-like behaviors. Children with significant substance abuse needs that require intensive treatment are also eligible. However, children in need of acute detoxification services should have this need met prior to being appropriate for referral to the program.

These children have not responded favorably to less intensive interventions, or have been denied admission or discharged from various placements because of their emotional and behavioral problems. There is a need for constant adult supervision and intense treatment, which may include the use of psychotropic medication. This is a population at high risk of hospitalization or institutionalization because of the pervasive nature of their problems.

Youth with an IQ of 70 or below, based on assessment of both intellectual and adaptive level of functioning, according to testing by professionally accepted assessment instruments must be reviewed on a case-by-case basis to determine if the child could be appropriately served. IQ cannot be only determining factor for rejection.

Although usually in good health, these children may require medical attention for health problems or for monitoring medications that may be required.

Ineligible youth are those who are actively homicidal, actively suicidal, or those children who have a psychosis not controlled with medication. Children who have required regular chemical or mechanical restraints for severe agitation or aggression are ineligible to the continuum. Youth who constantly display assaultive or combative behaviors (e.g., routinely assaulting other children and adults with weapons), those who consistently demonstrate self-injurious behaviors which may result in a fatal injury, those with complex medical conditions requiring isolation, those displaying predatory or aggressive sexual behaviors, children who have displayed major acts of violence or aggression such as rape, unless the program is designed to serve sex offenders, and children who have displayed behaviors such as arson, assault with a deadly weapon, murder, and attempted murder within the past six (6) months are also ineligible for admission.

Children enter a continuum program at a specified level of service, i.e. Level III. The provider is then responsible for arranging all services needed by the child and family, progressing the child through to less restrictive and more home/community based placements/services as soon as possible.

Continuum of Care is a service-based model of care that purchases the outcome of successful permanency for children and involvement of all individuals identified on the child's permanency plan. Continuums must admit, on a monthly basis, a minimum number of children.

In addition to residential treatment, group care, and foster care, continuums provide home/community-based services that will facilitate successful reunification of the child with the family. Continuums ensure 80% success in reunification or other permanency arrangements for children served by the program. Success within the continuum is defined as the outcome of the child being maintained with family, adoption, relative, independent living or final permanency plan goal for nine (9) consecutive months.

Appropriate court and Departmental approvals must be obtained prior to returning children to the home or allowing children to remain in-home for treatment. In all cases, the Department of Children's Services (DCS) case manager, family, and involved adults must receive verbal or written notification prior to a child being moved within the continuum.

The Provider, in conjunction with the DCS case manager, family, involved adults, and age appropriate child shall design and implement an individualized treatment plan based on the unique needs of each child and family. The Provider's individualized treatment plan will follow and enhance the State's Permanency Plan of Care developed by the State's case managers.

Monthly progress reports and treatment summaries shall be completed for each child enrolled in the continuum program. Reports shall be forwarded to the Child and Family Case Manager and Resource Manager.

Level III components of the continuum must include, within the per diem rate, the following services: support services, therapy, educational services, structured treatment activities, and adjunct/specialized services. Services must be provided as outlined in each youth's Plan of Care through providers qualified as outlined in the Provider Policy Manual. These services are defined as follows:

- Therapy – requires direct services in the form of individual, group, and/or family therapy, in addition case management, and treatment planning. For programs specifically serving sex offenders, therapy should address sexual perpetration issues in addition to meeting other therapy needs.
- Educational Services - educational needs must be met through the least restrictive environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs. Programs must also have or subcontract for self contained educational services, if needed by a child. A staff person must act as liaison between the treatment program and the community based educational system. Providers with on-site educational programs will provide both general and special education programs for children who do not attend local public schools.
- Structured Treatment Activities - involves structured group activities in residential and group care, designed to encourage, direct, and instruct children in the acquisition of skills needed to develop self-sufficiency and personal competence, and prevent or reduce the need for institutionalized care. These activities should account for four (4) hours of daily programs. Programs must have or subcontract for intensive day treatment services (licensed through Tennessee Department of Mental Health/Developmental Disabilities) if needed to meet the needs of a child.
- Adjunct and Specialized Services - specialized services should be obtained by utilizing community resources whenever possible. Some support or therapeutic services above the basic core services, such as sexual abuse counseling or substance abuse intervention, may be necessary and must be provided by consultants or therapists to meet special needs of children. Appropriately licensed certified or supervised professionals must provide therapy services.
- Case Management – case coordination services provided by an individual, who at a minimum, has a bachelor's degree in one of the social sciences. Case management includes developing the Family Service Plan, monitoring implementation of the plan, and locating all services and placements a child and/or family may need while enrolled in the continuum. It also includes documenting progress, problems, maintaining contacts with the custody department and Resource Managers, revising the Family Service Plan, as needed, maintaining ongoing contacts with the child and/or family, planning and implementing the progression of a child/family through the continuum, aftercare planning, and monitoring of aftercare services.

Services provided to children and families in any level of the continuum either directly by the provider or coordinated by the provider include, but not are not limited to, the following, as determined by the treatment or permanency plan:

- Individual, Group, Family, Marriage and/or Multi-Family Therapy;
- Parenting Skills – individualized coaching and training to assist parents with issues related to discipline, child development, child-rearing skills, and behavioral intervention
- Sexual Abuse Therapy and Sexual Perpetration Therapy – therapy and intervention services to address issues related to sexual abuse and sexually reactive behaviors;
- Substance Abuse Therapy – Therapy and intervention services targeting issues related to alcohol and/or drug misuse;
- Emergency Placement Services – services available 24 hours a day through on-call system which stabilize children and families by locating alternative short term placement
- Specialized Educational Services - services which supplement specialized services being provided by the local school system or Provider's in-house school;
- Vocational Assessments/Services/Planning/Training - vocational aptitude and interest surveys must be administered by properly trained and/or licensed professionals. Vocational training or services may be accomplished through enrolling the child in accredited vocational training courses or approved apprenticeships;
- Job Placement Assistance - assistance provided by the Provider, contracted staff, certified guidance counselor, school system, or other approved entity, in helping a child find appropriate part or full time employment;
- Independent Living Education/Arrangements - this service is defined as enrolling the child in an appropriately licensed independent living program, or providing supervision and support services to a child in a residential placement which the Provider has helped to locate and secure; case management and planning by a person possessing, at a minimum, a bachelor's degree in one of the social sciences;
- Dietetic and Nutrition Services - services of one hour or more in duration which are provided, at a minimum, by a certified dietitian, medical doctor, or licensed registered nurse;
- Coordination of Medical and Nursing Services - Coordination of services provided by a licensed physician, or licensed registered nurse, of the type and duration indicated by documented medical need;
- Crisis Intervention/Stabilization - services provided on a twenty-four (24) hour basis to a child and/or family experiencing a medical, mental health, parent/child interaction, or other significant emergency need. Services must, at a minimum, be provided by an individual with a bachelor's degree in one of the social sciences and who has access to licensed professionals possessing, at a minimum, a Master's degree in one of the behavioral sciences;
- Community Support Services - a variety of support services provided to the family in the home; must not include support services funded by the State under separate contractual arrangements;

- Mental Retardation Services - specialized services designed to address the developmental deficits and skills development needs of individuals with validated diagnoses of mental retardation;
- Family Planning Assistance - education and guidance provided to a child and/or family regarding planning/preventing child birth; may include alternatives available for pregnant teens;
- Respite - services to provide agency foster parents or family members appropriate periods of break in care giving;
- Adoption Assistance Services - services designed to assist in locating and placing eligible children in adoptive homes.
- Home-Based Treatment - an array of services, which may be provided to a family to keep the family intact and facilitate successful reunification. Home-based treatment services provided within the continuum must address the systematic factors contributing to the problems of children and families. Treatment must be family-focused and address reunification issues, as indicated in the treatment and/or permanency plan. Home- Based Treatment services include, but are not limited to the array of services coordinated or provided by the continuum.

Home-based treatment services are intensive treatment case-management and support services provided to the child and family to keep the family intact or to ensure successful reunification. Home-based services are not to be construed as after care services.

Home-based treatment services assist the family and child to remain together rather than placement in psychiatric hospitals, residential programs, or foster care.

Home-based treatment services must be designed to reduce the length of stay for children currently in residential programs, therapeutic foster care, and psychiatric hospitals, providing them with a successful transition home. Additionally, they should provide or coordinate comprehensive mental health treatment and social support services to the entire family in the home. Home-based services should identify family members, friends, and other members of the community who are willing to have the child live in their homes or otherwise serve as family support.

**Minimum Standards for Home based treatment services must consist of the following:**

- Family Service agreement with treatment plan and staffing. The Staffing must include all team members;
- Home-based service workers must have a minimum of a Bachelor's degree in the social sciences or related field and at least one year of pertinent work experience preferably having been in a residential setting and supervisory experience being desirable, or, a Master's Degree;
- Home based services will have Staff dedicated and trained to a reorganized home base treatment model with documentation of training. Staffing ratio will be no more than one staff to ten (10) families, with fluctuation allowed, based on the levels of intervention needed;

- Twenty-four (24) hour on call crisis services with a plan to access face-to-face services within no more than two (2) hours;
- Intensive in-home services will require at least two (2) contacts weekly with a minimum of one (1) time weekly face-to-face contact with primary caretaker and child;
- Assessment/treatment plan, progress notes, monthly progress reports will address family, safety, education, peers and continuing needs. These reports will be submitted to the Residential Case manager, DCS Case managers and the Resource managers monthly;
- Quarterly staffing with all active participants will occur;
- Respite services will be available to meet treatment and safety needs.

Community based services provided by the Provider or other contracted Provider in-home based treatment, must not include services which are already funded by the state under separate contractual arrangements.

The frequency and intensity of interventions shall vary as the child and family progress through the continuum. All services provided are to be culturally competent, recognizing the cultural and ethnic heritage of children and families being served.

Each child admitted into the continuum shall have identified specific milestones for the child and family to reach in order to progress through various levels of the continuum. Step down to lower intensity must be fully documented through a staffing process, which is documented in the I.P.P. (individualized treatment plan) and includes all involved adults and age appropriate children.

Participation from the family in treatment planning shall be actively encouraged.

The Provider shall have the responsibility of determining, with input from home county , involved adults, and child, when each child/family is ready for movement through the continuum and the appropriate subsequent levels of care or services required following TennCare appeals and notice guidelines. DCS case manager should be an active participant in these decisions and shall be notified prior to the movement of the child/family within the continuum.

Written approval of DCS case manager, Child Abuse Review Team (CART), and the court must be obtained in child protective services (CPS) cases in which the department has petitioned for custody of the child if the child is to be allowed unsupervised visits with the persons alleged to have been responsible for the abuse or neglect of the child.

Written approval of DCS case manager, CART, and the court must also be obtained prior to the reunification of a CPS child with individuals who were deemed to have been responsible for the abuse/neglect and subsequent removal of the child from the home.

## **C. ALLOWANCES**

Allowances, as specified in the “General Requirements” section of the Provider Manual, are required for children enrolled in residential components of the continuum. Allowances may be given to children, at the discretion of the Continuum Provider, after a child is returned home or other permanency arrangements are made.

## **D. OUTCOME RESEARCH/IDENTIFIED SUCCESS CRITERIA**

All children discharged from the Continuum shall become part of the Provider’s outcome evaluation and aftercare program. Discharge (D/C) occurs when the child and family are no longer receiving reimbursable continuum services. After care services are follow up services provided post D/C (after billing stops) to monitor a child and families progress and where possible support permanency after care is a non-billable service. This outcome evaluation and aftercare program shall consist of the following:

- Assessments of family and individual functioning at admission and discharge to a permanent placement;
- Monthly phone contact post discharge at 1, 2, 3 and 6 months;
- Phone contact will assess safety, education, peer relations, individual needs, medication and family community areas on discharge plan;
- Periodic evaluation of youth placement and families’ activities at 3, 9, and 12 months;
- Post discharge to a permanent placement;
- Twenty-four (24) hour on call support, referral or other services will be provided at the discretion of the Provider.

Outcome indicators shall include:

- Placement status at discharge and at each evaluation point;
- Assessment of functional living skills (e.g. ability to function in school environment, etc.);
- History of legal system involvement;
- Use of mental health services;
- History of out-of-home placements;
- Analysis and outcomes shall include comparison of length of stay averages and service utilization with specific measures of individual and family functioning.

The Provider shall, at the request and direction of the State, conduct additional research and provide information relative to the Continuum of Care Services Model.

On a monthly basis, the Provider shall submit to the Division of Quality Assurance reports that include the following information:

- The number of new children and families entering the continuum on a monthly basis;
- The number of children and families served monthly;
- The number of children and families served year to date;

- The average length of stay for children and families currently in the continuum;
- Outcomes statistics as indicated in the contract;
- Other pertinent issues related to the service delivery system.

“Program success” is defined by the State as having an identified success rate in the numbers of children who are successfully maintained in their homes or other permanent placement for at least nine (9) consecutive months following placement. For children free for adoption and placed for adoption, nine consecutive months in the adoptive home is the continuum measure for success. The nine-month period for children reunified with their families begins at the time of physical placement back in the home. For children being adopted, the nine-month required period begins when the adoptive home agreement is signed.

Children who have not completed the continuum program (e.g. have not completed nine consecutive months of successful reunification with their families or nine consecutive months of successful placement in alternative “permanent” living arrangements), *and* who are requested by the Provider to be removed from the program, shall be considered and counted as “program failures”.

Children who run away from the program, shall be considered and counted as program failures only if they have been in the continuum for at least three (3) consecutive months and, remain on runaway status for more than ten (10) days, or are apprehended prior to ten (10) days but are not accepted back into the continuum. The Provider shall be construed to have refused to accept a child back into the continuum if the Provider refuses to admit the child into a program operated/contracted by the Provider, and/or refuses to provide services to the child and family at any level within the continuum.

## **E. DISCHARGES**

The Continuum of Care Services Model is designed to implement a variety of services based on the varying needs of children and families, it is expected that discharge of a child, prior to completion of the program, will not be requested.

The Provider shall not request the removal of a child from the program for such reasons as non-compliance with house rules, reported lack of “motivation”, or lack of progress in the program.

The Provider may request removal of a child from the continuum program if the child has validated, diagnosed, or adjudicated behaviors, which would place him in the category of children who are not eligible for admission to the program. The Provider shall be expected to exhaust all available means of service intervention prior to requesting such discharges. De-authorizations may occur if appropriate services are not being provided.

De-authorization should be a consensus decision between the Provider, family and involved adults, age appropriate children, DCS case manager and resource manager. If this is not the case, an appeal should be filed, or mediation steps should be taken.

The Provider shall adhere to all State approved guidelines for staffing and discharge planning prior to any child's removal from the program.

Children who fail to complete at least nine (9) consecutive months of successful reunification in their "permanent" placement (e.g. home of parent or guardian, home of relatives, adoptive home, or permanent foster home) shall be provided with a revised Family Service Plan and shall be served by the continuum model at no additional cost to the State or such cases shall be determined "program failures" and be counted against the Provider's maximum allowable failure rate.

Children who are successfully or unsuccessfully discharged from the Continuum Program and who are no longer receiving services from the Provider may be referred again to the Provider for enrollment in the continuum program through the regular referral process. However, these youth must be prioritized on the regional resource management system's waiting list and an appropriate opening must be available in the Provider's continuum.

The Provider shall be responsible for the provision of appropriate services to children placed in detention. In such cases, the child and family shall be provided with a revised Family Service Plan and the child shall be returned to an appropriate level within the continuum following release from detention.

The Provider shall seek payment for required psychiatric hospitalization through the Behavioral Health Organization (BHO) to which the child is assigned or through the private insurance maintained by the child's family. If the appropriate certifications are not obtained, and/or the BHO or family's private insurance declines to pay the cost of psychiatric hospitalization, the cost shall be borne by the Provider.

## **XIX. LEVEL III SPECIAL NEEDS CONTINUUM**

### **A. PROGRAM DESCRIPTION**

Continuum of Care is a service-based model of care which purchases the outcome of successful permanency for children. Continuums have greater flexibility in designing services for the child and family, the ability to facilitate more rapid movement of the child to permanency and the ability to customize the delivery of services to each child and family in the least restrictive and cost effective manner. Staffing and other program requirements in each level of care must be met, as outlined in this policy manual under the specific level of service.

### **B. POPULATION SERVED**

Children in this continuum are all either developmentally delayed with a psychiatric diagnosis, sexual offenders, or dually diagnosed sexual offenders. Children referred for admission to the Provider's program at the Level III point of entry will have a Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) clinical diagnosis of a mental disorder or will have been identified by a mental health professional as having serious emotional and/or behavioral problems and be in need of treatment at this level. Additionally, the child's family or primary caretaker(s) may be displaying a dysfunctional pattern of interaction or be exhibiting severe problem behaviors. These problems must pose a severe level of impairment to overall functioning in multiple areas.

These children may exhibit delinquent, chronic runaway, or manipulative behaviors. They may have difficulty maintaining self-control, display poor self-esteem, and have difficulty accepting authority. This population may exhibit significant disruptive behaviors such as persistent or unpredictable aggression, and be at moderate to serious risk of causing harm to themselves or others.

These children may be diagnosed as autistic, or display autistic-like behaviors. Children with significant substance abuse needs that require intensive treatment are also eligible. However, children in need of acute detoxification services should have this need met prior to being appropriate for referral to the program.

These children have not responded favorably to less intensive interventions, or have been denied admission or discharged from various placements because of their emotional and behavioral problems. There is a need for constant adult supervision and intense treatment, which may include the use of psychotropic medication. This is a population at high risk of hospitalization or institutionalization because of the pervasive nature of their problems.

Although usually in good health, these children may require medical attention for health problems or for monitoring medications that may be required.

Ineligible youth are those who are actively homicidal, actively suicidal, or those children who have a psychosis not controlled with medication. Children who have required regular chemical or mechanical restraints for severe agitation or aggression are ineligible to the continuum. Youth who constantly display assaultive or combative behaviors (e.g., routinely assaulting other children and adults with weapons), those who consistently demonstrate self-injurious behaviors which may result in a fatal injury, those with complex medical conditions requiring isolation, those displaying predatory or aggressive sexual behaviors, unless the program is a sexual offender treatment program, children who have displayed major acts of violence or aggression such as rape, unless the program is designed to serve sex offenders, and children who have displayed behaviors such as arson, assault with a deadly weapon, murder, and attempted murder within the past six (6) months are also ineligible for admission.

Children enter a continuum program at a specified level of service, i.e. Level III. The provider is then responsible for arranging all services needed by the child and family, progressing the child through to less restrictive and more home/community based placements/services as soon as possible.

Continuum of Care is a service-based model of care that purchases the outcome of successful permanency for children and involvement of all individuals identified on the child's permanency plan. Continuums must admit, on a monthly basis, a minimum number of children.

In addition to residential treatment, group care, and foster care, continuums provide home/community-based services that will facilitate successful reunification of the child with the family. Continuums ensure 80% success in reunification or other permanency arrangements for children served by the program. Success within the continuum is defined as the outcome of the child being maintained with family, adoption, relative, independent living or final permanency plan goal for nine (9) consecutive months. Appropriate court and Departmental approvals must be obtained prior to returning children to the home or allowing children to remain in-home for treatment. In all cases, the Department of Children's Services (DCS) case manager, family, and involved adults must receive verbal or written notification prior to a child being moved within the continuum.

The Provider, in conjunction with the DCS case manager, family, involved adults, and age appropriate child shall design and implement an individualized treatment plan based on the unique needs of each child and family. The Provider's individualized treatment plan will follow and enhance the State's Permanency Plan of Care developed by the State's case managers.

Monthly progress reports and treatment summaries shall be completed for each child enrolled in the continuum program. Reports shall be forwarded to the Child and Family Case Manager and Resource Manager.

Level III components of the continuum must include, within the per diem rate, the following services: support services, therapy, educational services, structured treatment

activities, and adjunct/specialized services. Services must be provided as outlined in each youth's Plan of Care through providers qualified as outlined in the Provider Policy Manual. These services are defined as follows:

- Therapy – requires direct services in the form of individual, group, and/or family therapy, in addition case management, and treatment planning. For programs specifically serving sex offenders, therapy should address sexual perpetration issues in addition to meeting other therapy needs.
- Educational Services - educational needs must be met through the least restrictive environment appropriate to meet the educational and treatment needs of the child. This includes both general and special education programs. Programs must also have or subcontract for self contained educational services, if needed by a child. A staff person must act as liaison between the treatment program and the community based educational system. Providers with on-site educational programs will provide both general and special education programs for children who do not attend local public schools.
- Structured Treatment Activities - involves structured group activities in residential and group care, designed to encourage, direct, and instruct children in the acquisition of skills needed to develop self-sufficiency and personal competence, and prevent or reduce the need for institutionalized care. These activities should account for four (4) hours of daily programs. Programs must have or subcontract for intensive day treatment services (licensed through Tennessee Department of Mental Health/Developmental Disabilities) if needed to meet the needs of a child.
- Adjunct and Specialized Services - specialized services should be obtained by utilizing community resources whenever possible. Some support or therapeutic services above the basic core services, such as sexual abuse counseling or substance abuse intervention, may be necessary and must be provided by consultants or therapists to meet special needs of children. Appropriately licensed certified or supervised professionals must provide therapy services.
- Case Management – case coordination services provided by an individual, who at a minimum, has a bachelor's degree in one of the social sciences. Case management includes developing the Family Service Plan, monitoring implementation of the plan, and locating all services and placements a child and/or family may need while enrolled in the continuum. It also includes documenting progress, problems, maintaining contacts with the custody department and Resource Managers, revising the Family Service Plan, as needed, maintaining ongoing contacts with the child and/or family, planning and implementing the progression of a child/family through the continuum, aftercare planning, and monitoring of aftercare services.

Services provided to children and families in any level of the continuum either directly by the provider or coordinated by the provider include, but not are not limited to, the following, as determined by the treatment or permanency plan:

- Individual, Group, Family, Marriage and/or Multi-Family Therapy;
- Parenting Skills – individualized coaching and training to assist parents with issues related to discipline, child development, child-rearing skills, and behavioral intervention

- Sexual Abuse Therapy and Sexual Perpetration Therapy – therapy and intervention services to address issues related to sexual abuse and sexually reactive behaviors;
- Substance Abuse Therapy – Therapy and intervention services targeting issues related to alcohol and/or drug misuse;
- Emergency Placement Services – services available 24 hours a day through on-call system which stabilize children and families by locating alternative short term placement
- Specialized Educational Services - services which supplement specialized services being provided by the local school system or Provider's in-house school;
- Vocational Assessments/Services/Planning/Training - vocational aptitude and interest surveys must be administered by properly trained and/or licensed professionals. Vocational training or services may be accomplished through enrolling the child in accredited vocational training courses or approved apprenticeships;
- Job Placement Assistance - assistance provided by the Provider, contracted staff, certified guidance counselor, school system, or other approved entity, in helping a child find appropriate part or full time employment;
- Independent Living Education/Arrangements - this service is defined as enrolling the child in an appropriately licensed independent living program, or providing supervision and support services to a child in a residential placement which the Provider has helped to locate and secure; case management and planning by a person possessing, at a minimum, a bachelor's degree in one of the social sciences;
- Dietetic and Nutrition Services - services of one hour or more in duration which are provided, at a minimum, by a certified dietitian, medical doctor, or licensed registered nurse;
- Coordination of Medical and Nursing Services - Coordination of services provided by a licensed physician, or licensed registered nurse, of the type and duration indicated by documented medical need;
- Crisis Intervention/Stabilization - services provided on a twenty-four (24) hour basis to a child and/or family experiencing a medical, mental health, parent/child interaction, or other significant emergency need. Services must, at a minimum, be provided by an individual with a bachelor's degree in one of the social sciences and who has access to licensed professionals possessing, at a minimum, a Master's degree in one of the behavioral sciences;
- Community Support Services - a variety of support services provided to the family in the home; must not include support services funded by the State under separate contractual arrangements;
- Mental Retardation Services - specialized services designed to address the developmental deficits and skills development needs of individuals with validated diagnoses of mental retardation;
- Family Planning Assistance - education and guidance provided to a child and/or family regarding planning/preventing child birth; may include alternatives available for pregnant teens;

- Respite - services to provide agency foster parents or family members appropriate periods of break in care giving;
- Adoption Assistance Services - services designed to assist in locating and placing eligible children in adoptive homes.
- Home-Based Treatment - an array of services, which may be provided to a family to keep the family intact and facilitate successful reunification. Home-based treatment services provided within the continuum must address the systematic factors contributing to the problems of children and families. Treatment must be family-focused and address reunification issues, as indicated in the treatment and/or permanency plan. Home- Based Treatment services include, but are not limited to the array of services coordinated or provided by the continuum.

Home-based treatment services are intensive treatment case-management and support services provided to the child and family to keep the family intact or to ensure successful reunification. Home-based services are not to be construed as after care services.

Home-based treatment services assist the family and child to remain together rather than placement in psychiatric hospitals, residential programs, or foster care.

Home-based treatment services must be designed to reduce the length of stay for children currently in residential programs, therapeutic foster care, and psychiatric hospitals, providing them with a successful transition home. Additionally, they should provide or coordinate comprehensive mental health treatment and social support services to the entire family in the home. Home-based services should identify family members, friends, and other members of the community who are willing to have the child live in their homes or otherwise serve as family support.

**Minimum Standards for Home-based treatment services must consist of the following:**

- Family Service agreement with treatment plan and staffing. The Staffing must include all team members;
- Home-based service workers must have a minimum of a Bachelor's degree in the social sciences or related field and at least one year of pertinent work experience preferably having been in a residential setting and supervisory experience being desirable, or, a Master's Degree;
- Home based services will have Staff dedicated and trained to a reorganized home base treatment model with documentation of training. Staffing ratio will be no more than one staff to ten (10) families, with fluctuation allowed, based on the levels of intervention needed;
- Twenty-four (24) hour on call crisis services with a plan to access face-to-face services within no more than two (2) hours;
- Intensive in-home services will require at least two (2) contacts weekly with a minimum of one (1) time weekly face-to-face contact with primary caretaker and child;

- Assessment/treatment plan, progress notes, monthly progress reports will address family, safety, education, peers and continuing needs. These reports will be submitted to the Residential Case manager, DCS Case managers and the Resource managers monthly;
- Quarterly staffing with all active participants will occur;
- Respite services will be available to meet treatment and safety needs.

Community based services provided by the Provider or other contracted Provider in-home based treatment, must not include services which are already funded by the state under separate contractual arrangements.

The frequency and intensity of interventions shall vary as the child and family progress through the continuum. All services provided are to be culturally competent, recognizing the cultural and ethnic heritage of children and families being served.

Each child admitted into the continuum shall have identified specific milestones for the child and family to reach in order to progress through various levels of the continuum. Step down to lower intensity must be fully documented through a staffing process, which is documented in the I.P.P. (individualized treatment plan) and includes all involved adults and age appropriate children.

Participation from the family in treatment planning shall be actively encouraged.

The Provider shall have the responsibility of determining, with input from home county , involved adults, and child, when each child/family is ready for movement through the continuum and the appropriate subsequent levels of care or services required following TennCare appeals and notice guidelines. DCS case manager should be an active participant in these decisions and shall be notified prior to the movement of the child/family within the continuum.

Written approval of DCS case manager, Child Abuse Review Team (CART), and the court must be obtained in child protective services (CPS) cases in which the department has petitioned for custody of the child if the child is to be allowed unsupervised visits with the persons alleged to have been responsible for the abuse or neglect of the child.

Written approval of DCS case manager, CART, and the court must also be obtained prior to the reunification of a CPS child with individuals who were deemed to have been responsible for the abuse/neglect and subsequent removal of the child from the home.

### **C. ALLOWANCES**

Allowances, as specified in the “General Requirements” section of the Provider Manual, are required for children enrolled in residential components of the continuum. Allowances may be given to children, at the discretion of the Continuum Provider, after a child is returned home or other permanency arrangements are made.

#### **D. OUTCOME RESEARCH/IDENTIFIED SUCCESS CRITERIA**

All children discharged from the Continuum shall become part of the Provider's outcome evaluation and aftercare program. Discharge (D/C) occurs when the child and family are no longer receiving reimbursable continuum services. After care services are follow up services provided post D/C (after billing stops) to monitor a child and families progress and where possible support permanency after care is a non-billable service. This outcome evaluation and aftercare program shall consist of the following:

- Assessments of family and individual functioning at admission and discharge to a permanent placement;
- Monthly phone contact post discharge at 1, 2, 3 and 6 months;
- Phone contact will assess safety, education, peer relations, individual needs, medication and family community areas on discharge plan;
- Periodic evaluation of youth placement and families' activities at 3, 9, and 12 months;
- Post discharge to a permanent placement;
- Twenty-four (24) hour on call support, referral or other services will be provided at the discretion of the Provider.

Outcome indicators shall include:

- Placement status at discharge and at each evaluation point;
- Assessment of functional living skills (e.g. ability to function in school environment, etc.);
- History of legal system involvement;
- Use of mental health services;
- History of out-of-home placements;
- Analysis and outcomes shall include comparison of length of stay averages and service utilization with specific measures of individual and family functioning.

The Provider shall, at the request and direction of the State, conduct additional research and provide information relative to the Continuum of Care Services Model.

On a monthly basis, the Provider shall submit to the Division of Quality Assurance reports that include the following information:

- The number of new children and families entering the continuum on a monthly basis;
- The number of children and families served monthly;
- The number of children and families served year to date;
- The average length of stay for children and families currently in the continuum;
- Outcomes statistics as indicated in the contract;
- Other pertinent issues related to the service delivery system.

"Program success" is defined by the State as having an identified success rate in the numbers of children who are successfully maintained in their homes or other permanent placement for at least nine (9) consecutive months following placement. For children free for adoption and placed for adoption, nine consecutive months in the adoptive home

is the continuum measure for success. The nine-month period for children reunified with their families begins at the time of physical placement back in the home. For children being adopted, the nine-month required period begins when the adoptive home agreement is signed.

Children who have not completed the continuum program (e.g. have not completed nine consecutive months of successful reunification with their families or nine consecutive months of successful placement in alternative “permanent” living arrangements), *and* who are requested by the Provider to be removed from the program, shall be considered and counted as “program failures”.

Children who run away from the program, shall be considered and counted as program failures only if they have been in the continuum for at least three (3) consecutive months and, remain on runaway status for more than ten (10) days, or are apprehended prior to ten (10) days but are not accepted back into the continuum. The Provider shall be construed to have refused to accept a child back into the continuum if the Provider refuses to admit the child into a program operated/contracted by the Provider, and/or refuses to provide services to the child and family at any level within the continuum.

## **E. DISCHARGES**

The Continuum of Care Services Model is designed to implement a variety of services based on the varying needs of children and families, it is expected that discharge of a child, prior to completion of the program, will not be requested.

The Provider shall not request the removal of a child from the program for such reasons as non-compliance with house rules, reported lack of “motivation”, or lack of progress in the program.

The Provider may request removal of a child from the continuum program if the child has validated, diagnosed, or adjudicated behaviors, which would place him in the category of children who are not eligible for admission to the program. The Provider shall be expected to exhaust all available means of service intervention prior to requesting such discharges. De-authorizations may occur if appropriate services are not being provided.

De-authorization should be a consensus decision between the Provider, family and involved adults, age appropriate children, DCS case manager and resource manager. If this is not the case, an appeal should be filed, or mediation steps should be taken.

The Provider shall adhere to all State approved guidelines for staffing and discharge planning prior to any child’s removal from the program.

Children who fail to complete at least nine (9) months consecutive months of successful reunification in their “permanent” placement (e.g. home of parent or guardian, home of relatives, adoptive home, or permanent foster home) shall be provided with a revised Family Service Plan and shall be served by the continuum model at no additional cost to

the State or such cases shall be determined “program failures” and be counted against the Provider’s maximum allowable failure rate.

Children who are successfully or unsuccessfully discharged from the Continuum Program and who are no longer receiving services from the Provider may be referred again to the Provider for enrollment in the continuum program through the regular referral process. However, these youth must be prioritized on the regional resource management system’s waiting list and an appropriate opening must be available in the Provider’s continuum.

The Provider shall be responsible for the provision of appropriate services to children placed in detention. In such cases, the child and family shall be provided with a revised Family Service Plan and the child shall be returned to an appropriate level within the continuum following release from detention.

The Provider shall seek payment for required psychiatric hospitalization through the Behavioral Health Organization (BHO) to which the child is assigned or through the private insurance maintained by the child’s family. If the appropriate certifications are not obtained, and/or the BHO or family’s private insurance declines to pay the cost of psychiatric hospitalization, the cost shall be borne by the Provider.

## **XX. LEVEL IV INPATIENT PROGRAMS (HOSPITAL BASED)**

### **A. PROGRAM DESCRIPTION**

Level IV programs provide non-acute psychiatric hospitalization, which is a physician-directed level of care focused on those clinical issues that cannot be addressed in a less restrictive setting and/or that must be addressed/resolved in order for the child to move to a less restrictive setting. All admissions to Level IV programs must either meet the criteria for voluntary admission subject to the availability of suitable accommodations as defined by the hospital or meet the criteria as specified by state law pertaining to involuntary admissions. As a hospital-based program, the final authority for admission and discharge decisions lies with the physician. The child's treatment team under the leadership of the physician makes decisions regarding which clinical issues are addressed on the plan of care, including the sequence in which they are addressed. The use of isolation or restraint in Level IV programs shall be directed by a physician and must be in compliance with applicable statutory, licensure, and JCAHO requirements.

### **B. POPULATION SERVED**

Level IV programs operated under terms of this agreement shall be designed to serve children in the custody of the Department of Children's Services (DCS) who do not meet criteria for acute psychiatric hospitalization, but who continue to require specialized mental health services which are highly structured, therapeutically intensive, and provided within a hospital environment.

Children appropriate for admission to a Level IV program are between the ages of six (6) to eighteen (18) years of age, meet criteria for voluntary admission to a psychiatric hospital, have a DSM-IV clinical diagnosis, and have a documented need for ongoing intensive mental health treatment. These children typically have multiple mental health and/or behavioral treatment needs of lengthy duration. Children may display behavioral characteristics such as exhibiting self-harm, making suicidal threats or gestures, exhibiting psychotic behaviors, exhibiting assaultive behaviors, and behavior that may require use of isolation or restraints. These children may also have complex associated medical problems that require ongoing treatment and care (a Level IV program may refuse admission of a child who requires medical care that the Level IV program cannot appropriately provide). Many children admitted to Level IV programs will require ongoing administration and medical supervision of psychotropic medication that will necessitate ready access to appropriately licensed professionals, pharmacy, and laboratory services. In many cases, these children will have a history of multiple and extensive hospitalizations in psychiatric facilities and will be a high risk for subsequent admissions into acute facilities. Typical patterns of behavior exhibited by these children include runaway, delinquent, manipulative behaviors, poor self-control, poor self-esteem, substance abuse, and/or resistance to authority. Constant adult supervision and immediate access to licensed mental health personnel are necessary in Level IV programs.

Children with dual diagnosis of mental illness and mild mental retardation may be referred for screening for appropriateness of admission to a Level IV program. In order to be found appropriate, the referral must contain documentation of a current Axis I diagnosis of mental illness in addition to the mental retardation diagnosis. The referral must contain the results of a psychological evaluation conducted within the past twelve (12) months with scores on both the intellectual functioning and adaptive behavior tests that meet the generally accepted psychological definition of mild mental retardation.

Children and youth with histories of sexual offenses who require specialized treatment services are inappropriate for admission to a Level IV program that does not operate a sex offender treatment component. Children and youth with an Axis I diagnosis and moderate, severe, or profound mental retardation (IQ of 55 or lower) and concurrent limitations in adaptive skill areas (communication, self care, home living, social skills, community use, self direction, health and safety, functional academics, leisure, or work) are inappropriate for admission. Children and youth with any of the pervasive developmental disorders, i.e. Autistic Disorder, Rhetts Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Pervasive Developmental Disorder, NOS, are also inappropriate for admission to a Level IV program.

Upon request from DCS, a Level IV program may assess whether the needs of a child with a history of sexual offenses, moderate or severe mental retardation, or a pervasive developmental disorder could be met by the agency through the provision of specialized services appropriate to the child. Such services shall be provided through unique care agreements or other arrangements with DCS and are not considered within the scope of services provided through a Level IV program.

### **C. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

#### **1. Service Components Required of All Level IV Programs:**

- Twenty-four (24) hour awake staff
- Comprehensive assessment of the child, if not current (physical, psychiatric, social, academic, nutritional, speech, vision, etc.)
- Behavior management system of behavioral goals, earned points and levels, tangible and social reinforcement
- Social skills training
- Liaison/social services
- Recreational activities
- Daily living skills, including personal hygiene, community re-integration, etc.
- Discharge planning
- Tennessee Department of Education approved educational program, including regular, special, remedial, and vocational instruction.

**2. Service Components Required of Level IV Programs When Indicated on a Plan of Care:**

- Psychotropic medication management
- Routine laboratory, pharmacy, radiology, and EEG
- Psychological evaluation to assist in addressing educational and placement needs
- Nationally recognized crisis intervention techniques
- Group therapy
- Individual therapy
- Speech and language services
- Dietetic services
- Family therapy.

**NOTE:** *Level IV providers shall assure that a psychiatrist participates in the treatment process and signs the treatment plan for any child receiving psychotropic medication.*

**D. STAFFING PATTERNS**

- 24 hour awake staff is required.
- 1:5 staff/child supervision ratio is required during awake hours.
- At night at least one (1) awake staff person is required for each eight (8) children enrolled in the program.

**E. CASE RECORD/PLAN OF CARE**

Level IV programs licensed by TMHMR require development of a **Treatment Plan** within 10 days. Any other TMHMR licensing standards that exceed the requirements stated in this section or elsewhere in this manual must be adhered to by TMHMR-licensed Level IV programs.

Daily progress notes are required in the case record of each child. Progress notes must be based on the progress of the child and family in meeting identified treatment objectives, and should also include information on any significant incidents, home passes, and/or new treatment needs being evidenced by the child/family. **Documentation of milieu treatment with schedule must be included in the client file. A monthly progress report/treatment summary on each child in the program must be provided to the DCS case manager and the DCS/CSA resource manager for review. The IPP/Treatment Plan must be reviewed and updated/modified whenever indicated, but at least at the interval specified by applicable TMHMR licensing standards, or quarterly, whichever is more frequent. All members of and participants in the treatment team must receive adequate notice of and be encouraged to attend such staffings. All procedures must be carried out in compliance with the DCS Appeals Process.**

## **F. TRANSITION**

A child may transition from a Residential program into a foster care program. This transition may last up to two (2) months per each foster home placement attempted. The Department of Children's Services Regional Administrator shall approve the transition plan. The Provider shall be paid for days of service the child visits the foster parents for up to a maximum of fifteen (15) days per foster home placement attempted in accordance with the approved plan. The foster parents may also be reimbursed for days of service when the child is with them.

## **XXI. SPECIALIZED LEVEL IV INPATIENT PROGRAM (SPECIAL NEEDS)**

### **A. POPULATION SERVED**

Programs operated under terms of this agreement shall be designed to serve children in the custody of the Department of Children's Services (DCS), who do not meet criteria for acute inpatient psychiatric hospitalization, yet continue to require specialized mental health services which are highly structured, therapeutically intensive, and provided within a secure environment.

Children comprising this population shall be dually diagnosed with an Axis 1 diagnosis and moderate or severe mental retardation (I.Q. score of 55 or lower) and limitations in two (2) or more adaptive skill areas (communication, self care, home living, social skills, community use, self direction, health and safety, functional academics, leisure, and work).

Individuals with mild mental retardation with I.Q. scores in the lower range of mild mental retardation (below 65), with significant limitations in adaptive skills (lower scores on adaptive behavior measures of communication, self-care, or social skills than would be expected based on the I.Q. score), and whose needs could be more appropriately met in a special needs unit than in a general Level IV program may be considered for admission on a case-by-case basis. A child with any of the pervasive developmental disorders, i.e. Autistic Disorder, Rhetts Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Pervasive Developmental Disorder may be accepted on a case by case basis.

Children appropriate for admission to this program are between the ages of six (6) to eighteen (18) years of age, meet criteria for voluntary admission to a psychiatric hospital, have a clinical diagnosis from the current diagnostic manual, and/or have a documented need for ongoing intensive mental health treatment. These children typically have multiple mental health and/or behavioral treatment needs of lengthy duration. Children may have behavioral characteristics such as exhibiting self harm, making suicidal threats or gestures, exhibiting psychotic behaviors, exhibiting assaultive behaviors, and behavior which may require seclusion or restraint. For these children the use of seclusion and/or restraint shall be physician directed and in compliance with applicable statutory, licensure, and Joint Committee on Accreditation of Healthcare Organizations (JCAHO ) requirements. Also, these children may have complex associated medical problems, which require ongoing treatment and care. The child's primary care physician (PCP) will provide medical care to the extent possible. Many children admitted to this program will require ongoing administration and medical supervision of psychotropic medication that will necessitate ready access to appropriately licensed professionals, pharmacy, and laboratory services. In many cases, these children will have a history of multiple and extensive hospitalizations in psychiatric facilities and will be at high risk for subsequent admissions into acute facilities.

Typical patterns of behavior exhibited by these children include runaway, delinquent, manipulative behaviors, poor self-control, poor self-esteem, substance abuse, and/or resistance to authority. Constant adult supervision will be necessary.

## **B. REQUIRED COMPONENTS OF SERVICES PROVIDED WITHIN THE PER DIEM RATE**

- Twenty-four (24) hour awake staff in addition to the required staffing ratio outlined in Provider Policy Manual
- Comprehensive assessment of the child if not current (physical, psychiatric, social, academic, nutritional, speech, vision, etc.)
- Behavior management system of behavioral goals, earned points and levels, tangible and social reinforcement
- Social skills training
- Group therapy
- Liaison/social service
- Recreational activities
- Daily living skills including personal hygiene, community re-integration, etc.
- Discharge planning
- Tennessee Department of Education approved educational program including regular, special, remedial and vocational instruction.

The following components provided as needed per the Provider's Plan of Care:

- Psychotropic medication management
- Routine laboratory, pharmacy, radiology, and EEG
- Psychological evaluation to assist in addressing educational and placement needs
- Nationally recognized crisis intervention techniques
- Individual therapy
- Speech and language services
- Dietetic services
- Family therapy.

**NOTE:** *Level IV Providers shall assure that a psychiatrist participates in the treatment process and signs the treatment plan for any child receiving psychotropic medication.*

## **C. STAFFING PATTERNS**

- 24 hour awake staff is required.
- 1:5 staff/child supervision ratio is required during awake hours.
- At night at least one (1) awake staff person is required for each eight (8) children enrolled in the program.

#### **D. CASE RECORD/PLAN OF CARE**

Level IV programs licensed by TMHMR require development of a **Treatment Plan** within 10 days. Any other TMHMR licensing standards that exceed the requirements stated in this section or elsewhere in this manual must be adhered to by TMHMR-licensed Level IV programs.

Daily progress notes are required in the case record of each child. Progress notes must be based on the progress of the child and family in meeting identified treatment objectives, and should also include information on any significant incidents, home passes, and/or new treatment needs being evidenced by the child/family. Case recordings and all other documentation concerning contacts or developments in the cases of class members shall be added to the case file for that child within 30 days of the case work activity or development. The case files of class members shall contain adequate documentation tracking the services provided, progress, any change in placement of the child, and authorizations which document the approval for placements, treatment and services provided to each child. **Documentation of milieu treatment with schedule must be included in the client file. A monthly progress report/treatment summary on each child in the program must be provided to the DCS case manager and the DCS/CSA resource manager for review. The IPP/Treatment Plan must be reviewed and updated/modified whenever indicated, but at least at the interval specified by applicable TMHMR licensing standards, or quarterly, whichever is more frequent. All members of and participants in the treatment team must receive adequate notice of and be encouraged to attend such staffings. All procedures must be carried out in compliance with the DCS Appeals Process.**

#### **E. INELIGIBLE CHILDREN**

Children and youth who have committed violent acts, use of force, sexual offences, and due to the serious nature of their behavior and continued significant risk they pose to others and the community, requiring constant adult supervision and specialized services not provided in the service components of Level IV in-patient treatment, will not be admitted.

## **XXII. EDUCATION**

Educational services shall be provided on-site to eligible Department of Children's Services (DCS) custodial children in the Provider's residential facility. Children who are eligible for an on-site educational program are children who fall into one of the following categories of school age children in the custody of DCS :

- Children who have serious emotional or behavioral problems that preclude them from functioning in a classroom setting;
- Children who are in an emergency placement for a period of one (1) to thirty (30) days;
- Children who are in a hardware secured, enhanced staff secured, or staff secured facility and require constant close direct supervision with a minimum staff/child ratio of 1:8.

The Provider stipulates that the on-site educational program meets the following criteria:

- All students are transient in attendance which means that they may be in attendance for less than the full 180 school days;
- The Provider established the agency's program for the primary purpose of providing residential care for children. The educational program is secondary to the primary goal of residential care.

The Provider agrees to meet Rules, Regulations and Minimum Standards (RRMS) in the following areas:

- Special Educational requirements (0520-1-3-.09);
- Length of school year (0520-1-3-.03(1)(a));
- Attendance policy/laws (TCA 49-6-3001);
- Fire Marshall's report (0520-7-2-.06(1)(f));
- In-service (0520-7-20.03(7)(c)12(ii);
- Library materials collections (0520-1-3.07(3);
- Records and reports (0520-1-3.04(4);
- Report cards to parents (0520-1-3-.06);
- Graduation requirements (0520-1-3-.06)
- Student health services (0520-1-3-.08(4);
- Length of school day and class period (0520-1-3(2);

The Provider further agrees to meet the following minimum requirements:

- a. Teacher certification
  - All teachers must hold a Tennessee Teacher's License or permit;
  - Special Education students; must be taught by appropriately credentialed teachers;
  - Elementary school (K-8) teachers must have appropriate elementary endorsement;

- Secondary school (7-12) teachers must have Tennessee Teacher's License or permit.
  - b.** Each agency shall develop procedures for evaluation of all professional school personnel.
  - c.** Curriculum
    - The Individual Education Plan (I.E.P.) for each Special Education student must be followed;
    - All course offerings must meet state standards for curriculum frameworks and guides;
    - The school should continue the curriculum of each individual student; established by the base school that the student previously attended.
  - d.** Facilities
    - Provision of a book center at the program site with appropriate reading materials for the age span and reading abilities of the children in the program. If the facility is located in an area served by a public library or a library on wheels, the program can supplement the book center with books from the library;
    - All appropriate building codes, EPA standards, and safety standards in general must be met. All local, state, and federal building and site codes must be followed.
  - e.** Textbooks and Instruction Materials
    - Textbooks and individual materials for each student must be appropriate for the curriculum. The ideal situation for a greater individualized educational program is accessibility to computers with software that can assess the child's basic skills and give the child an opportunity to work on an individualized educational curriculum.
- 5.** The Provider shall facilitate the enrollment of a child in public school if that child can function in the classroom and it is in the child's best interest to attend public school.
- 6.** Payment for educational services is included in the per diem for Level 2 Special Population, Level 2 Special Needs, Level 2 Continuum, all Level 3 type contracts, Level 4 type contracts, Detention, and Primary Treatment Center. Education contracts attached to shelter or other contract types (as individually approved) are calculated as follows: For each child served, the Provider shall multiply the service unit rate by the number of days that the child actually received services.

## APPENDIX A

### 1. Administrative Policies and Procedures: 12.1

#### *“Return to Home Placement: Youth Adjudicated Delinquent”*

Includes Forms:

CS-0041 Rev. 11/96	Notification of Proposed Home Placement
CS-0130 (Rev. 11/96)	Return to Home Placement
CS-0156 (Rev. 11/96)	Violation Report
CS-0012 (Rev. 12/97)	Rules of Aftercare

### 2. Administrative Policies and Procedures: 12.2

#### *“Trial Home Visit/Termination of Custody: Youth Adjudicated Unruly Youth”*

Includes Forms:

CS-0482	Notice of Proposed Trial Home Visit Unruly Child
CS-0483	Notice, Motion, Order for Unruly

### 3. Administrative Policies and Procedures: 12.3

#### *“Release of Dependent and Neglected Children from State Custody”*

Includes Form:

CS-0494	Notice and Motion
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### 4. Administrative Policies and Procedures: 12.4

#### *“Release from Custody of Dependent and Neglected Youth at Age Eighteen”*

Includes Forms:

CS-0488	Right and Responsibilities at Age 18
CS-0489	Justification for Services

### 5. Administrative Policies and Procedures: 12.5

#### *“Passes for Youth Adjudicated Delinquent”*

Forms Needed:

CS-0058	Temporary Custody Agreement
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## APPENDIX B (Part I)

### 1. Obtaining And Using Psychological Evaluations

**From:** Mary Beth Franklyn  
**Subject:** Psychologicals

**Q: The judge ordered a psychological on a child I have during a permanency hearing. The CMHC says they don't do these.**

A: Psychologicals for TennCare children are covered as medically necessary.

1. Call the BHO to find out where to take the child within 14 days.
2. The provider can get one hour of testing in addition to the intake. That won't be enough. You will need to file a Psychological Evaluation Request Form with the BHO. Your Health Unit psychologist may have this form or you can obtain it directly from the BHO by calling either of the numbers shown above (both BHOs use the form). The form can be faxed to the BHO. You may need assistance filling out this form. If so, contact the Health Unit psychologist, he or she will assist you. The BHOs will approve no more than three hours, but these three hours combined with the one hour intake and one hour of testing that is automatically approved will give you a total of five hours.
3. If the testing is denied by the BHO, call the TennCare Representative so they may file an appeal OR call the Health Advocacy psychologists.

### 2. Administrative Policies and Procedures: 20.7

***“Early Periodic Screening Diagnosis and Treatment (EPSDT) Standards”***

Forms to be used are in the process of being approved through TennCare and DCS.

### 3. Administrative Policies and Procedures: 20.18

***“Administration of Psychotropic Medication”***

Needed Forms:

CS-0108 (Rev 10/98)

CS-0545

Consent for Treatment – Psychotropic Medication  
Informed Consent for Psychotropic Medications or  
Surgical Procedures

### 4. Other Forms:

CS0206 Rev. 8/99

Informed Consent to Routine Health Services  
for Minors

### 5. Emergency Evaluation and Inpatient Psych

The Youth Villages Specialized Crisis Services team should respond within one hour of being called. Appeal if they don't come at all (appeal to TennCare).

They must by statute pre-cert for any admission to an RMHI. If an individual is taken to the RMHI, Mobile Crisis will be called to pre-cert.

The BHO (both Premier and TBH) are using Mobile Crisis to pre-cert for all inpatient psych admissions. However, under their contract with TennCare, the BHO may *not* require prior authorization for any *emergency*.

Therefore, if Mobile Crisis does not arrive timely, an individual may be taken to a hospital and the hospital *can admit if* the individual is in need of emergency treatment. In such a circumstance (where Mobile Crisis did not arrive timely), a TennCare appeal should be filed (yes-after the fact) because there was a delay in service.

*Can the Regional Psychologist provide a first signature for involuntary treatment?*

Yes; a psychologist can provide that signature, and when an individual will be taken to a hospital in an emergency when Mobile Crisis is not involved because they did not come or were not called, it would be particularly appropriate for the psychologist to sign.

CS0088 Rev. 8/99

Informed Consent to Non-Routine Medical Care/  
Treatment for Minors

## 6. Health Unit Staff

Region	TennCare Representative	Nurse	Psychologist
<b>Davidson</b>	Valerie Sweatt 900 2 <sup>nd</sup> Avenue, North Nashville, TN 37243 615-253-5126 615-253-4208 - Fax	Patricia Slade,RN,MSN,MBA 900 2nd Avenue, North Nashville, TN 37243 615-253-5127 615-253-4208 - Fax 615-289-4726 - Cell	Ray Tesauro,ED.D.HSP 900 2nd Avenue, North Nashville, TN 37243 615-253-5125 615-253-4208 - Fax 888-824-7027 - Pager
<b>East Tennessee</b> Anderson, Blount, Campbell, Claiborne, Cocker, Grainger, Hamblen, Jefferson, Loudon, Monroe, Morgan, Roane, Scott, Sevier, Union	Sallie Beauchamp 182 Frank L. Diggs Dr. Suite 100 Clinton, TN 37716 865-425-4527 865-463-8402 - Fax	Scott Melton, RN 182 Frank L. Diggs Dr. Suite 100 Clinton, TN 37716 865-425-4517 865-463-8402 - Fax	Bill Daniel, Ph.D. 182 Frank L. Diggs Dr. Suite 100 Clinton, TN 37716 865-425-4546 865-463-8402 - Fax 877-205-6563 - Pager
<b>Hamilton</b>	Sara (Sally) Lockett 540 McCallie Avenue,Ste.300 Chattanooga, TN 37402 423-634-3494 423-634-6331-Fax	Chip Dantzler, RN 540 McCallie Avenue, Ste.300 Chattanooga, TN 37402 423-634-3493 423-634-6331-Fax	David Rose, Ph.D. 540 McCallie Avenue, Ste.300 Chattanooga, TN 37402 423-634-6063 423-634-6331-Fax
<b>Knox</b>	Carol Lowdermilk 3712 Middlebrook Pike Knoxville, TN 37921 865-594-7101 - Ext.15 865-637-8824-Fax	Katressa Tipton 3712 Middlebrook Pike Knoxville, TN 37921 865-594-7101 - Ext. 18 865-637-8824-Fax	Jim Montgomery III, Ph.D. 3712 Middlebrook Pike Knoxville, TN 37921 865-594-7101 Ext.19 865-637-8824-Fax
<b>Mid-Cumberland</b> Cheatham, Dickson, Houston, Humphreys, Montgomery, Robertson, Rutherford, Stewart, Sumner, Trousdale, Williamson, Wilson	Jacqueline Bryant (CSA) 531 MetroPlex, Ste. A-200 MetroPlex Gardens Nashville, TN 37211 615-333-5433 615-620-0050 or 0052 - Fax	Patsy Sanford, RN, MSHSA 531 Metroplex, Ste.A-200 Metroplex Gardens Nashville, TN 37211 615-333-5447 615-620-0050 or 0052-Fax	William Barry Boggs, Ph.D. 531 Metroplex, Ste.A-200 Metroplex Gardens Nashville, TN 37211 615-333-5422 615-620-0050 or 0052-Fax
<b>Northeast</b> Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington	Kathy Keen (CSA) 2513 Wesley Street, Suite 3 Johnson City, TN 37601 423-952-6038 423-854-5315 - Fax 423-818-4637 - Pager	Rebecca Reed,RN,BSN,ANP,CS 150 E. Main Street Mountain City, TN 37683 423-727-1052 423-727-5649-Fax 423-854-6662 - Pager	Martha Wike, Ph.D. 2513 Wesley St., Suite 3 Johnson City, TN 37601 423-952-7036 423-854-5315-Fax 423-854-6663 -Pager
<b>Northwest</b> Benton, Carroll, Crockett, Dyer, Gibson, Henry, Lake, Obion, Weakley	Janie Alexander (CSA) 1604 W. Reelfoot Ave. Union City, TN 38281-0368 731-884-2630 731-884-2644-Fax	Phyllis Parker, RN 1604 W. Reelfoot Ave. Union City, TN 38281-0368 731-884-2633 731-884-2644-Fax	Randy Phillips, LPC, MHSP 1604 W. Reelfoot Avenue Union City, TN 38281-0368 731-884-2633 731-884-2644-Fax

**Health Unit Staff Continued**

<b>Region</b>	<b>TennCare Representative</b>	<b>Nurse</b>	<b>Psychologist</b>
	Memphis, TN 38104 901-543-4633 901-543-7110-Fax	Memphis, TN 38103 901-578-4066 901-543-7110-Fax	Memphis, TN 38103 901-578-4142 901-543-7110 - Fax 901-447-8364 - Pager
<b>South Central</b> Bedford, Coffee, Giles, Hickman, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry, Wayne	Mike Stone 1610 Hatcher Lane Columbia, TN 38401 931-375-2000 931-375-2011-Fax	Lynn Pollard, MSN, RN,CPNP 1610 Hatcher Lane Columbia, TN 38401 931-375-2000 931-375-2011-Fax	Archie Carden, Ed.D 1610 Hatcher Lane Columbia, TN 38401 931-375-2000 931-375-2011-Fax
<b>Southeast</b> Bledsoe, Bradley, Franklin, Grundy, McMinn, Marion, Meigs, Polk, Rhea, Sequatchie	DeHavilland Rivers 1501 Riverside Drive, Suite 105 Chattanooga, TN 37406-4314 423-493-5948 - Ext. 2128 423-634-3120-Fax Main Office No. 423-493-5920	Cheryl Brazelton, RN, BSN 1501 Riverside Dr., Suite 105 Chattanooga, TN 37406-4314 423-493-5960 - Ext. 2140 423-634-3120-Fax	Norman West, Ph.D. 1501 Riverside Dr., Suite 105 Chattanooga, TN 37406-4314 423-493-5945 - Ext. 2125 423-634-3120-Fax
<b>Southwest</b> Chester, Decatur, Fayette, Hardeman, Hardin, Haywood, Henderson, Lauderdale, Madison, McNairy, Tipton	Tiffany Lusby-Spivey 33 Old Hickory Blvd., E Jackson, TN 38305 731-426-0780 / 731-426-0774 731-265-7023-Fax 731-887-0593 - Pager	Sara Webb, RN 33 Old Hickory Blvd., E Jackson, TN 38305 731-426-0782 731-265-7023-Fax 800-841-7243 Code# 31069 - Pager	Donna Cole, LCSW 33 Old Hickory Blvd., E. Jackson, TN 38305 731-426-0781 731-265-7023-Fax
<b>Upper Cumberland</b> Cannon, Clay, Cumberland, DeKalb, Fentress, Jackson, Macon, Overton, Pickett, Putnam, Smith, VanBuren, Warren, White	Rebecca Adcock 1300 Salem Road Cookeville, TN 38506 931-646-3026 931-520-1877-Fax	Tanna Short, MSN<RN-C,FNP 1300 Salem Road Cookeville, TN 38506 931-646-3027 931-520-1877 - Fax	Carolyn Valerio, Psy.D. 1300 Salem Road Cookeville, TN 38506 931-646-3025 931-520-1877 - Fax
<b>Central Office</b>	Laura A. Stewart, MTS, JD Exec. Asst. to the Commissioner 8 <sup>th</sup> Floor, Cordell Hull Bldg. 436 Sixth Avenue North Nashville, TN 37243-1290 615-253-4359 615-741-7322 – Fax 800-283-0007, Code #7139 – Pager	Vicki Peterson, MAT Program Coordinator 8 <sup>th</sup> Floor, Cordell Hull Bldg. 436 Sixth Avenue North Nashville, TN 37243-1290 615-253-6815 615-741-7322 – Fax	Tricia Henwood, Ph.D. Director of Medical and Behavioral Services 8 <sup>th</sup> Floor, Cordell Hull Bldg. 436 Sixth Avenue North Nashville, TN 37243-1290 615-532-9306

**7. TennCare MCO and BHO Covered Services**

## APPENDIX B (Part II)

### 1. [Administrative Policies and Procedures: 11.8](#)

*“Appeal Rights For DCS-Administered TennCare Services as Identified in the Permanency Plan”*

Needed Forms:

[Notice of Action](#)

[TennCare Medical Care Appeal Form](#)

### 2. **ADVOCACY: Getting TennCare To Work For Your Kids**

#### **Eligibility, MCOs, and PCPs:**

**Q: My child came into custody last week. She has TennCare and she is on Access Med Plus, but I don’t know the PCP.**

A: Email the TennCare Representative with the child’s name and social security number. They will call Access Med Plus and find out the name of the PCP. Remember to make the appointment for the EPSDT screen right away. You should get an appointment within 3 weeks of the date you call.

**Q: This kid has been in custody for 2 weeks and they still aren’t on TennCare. The foster mom says they have a rash and it is spreading.**

A: The foster mom should take the child to any local doctor who she can get a quick appointment with. She should ask the doctor for a HCFA 1500 billing form. This will have to be billed on the non-medical TennCare eligible claim form. Also, contact the TennCare Representative and they will help facilitate getting the child enrolled in TennCare As an uninsured through the Health Department if enrollment through the CWBC isn’t going to happen soon.

**Q: Donald is on BlueCare. He is from a little town east of Knoxville and came into custody 3 weeks ago. Now he is in Oak Ridge, and he needs his EPSDT. I don’t have time to drive him back to Knoxville to get this done at his PCP, which is assigned over there.**

A: For children on BlueCare, BlueCare will permit the child to see any doctor who is a PCP with BlueCare, but the child doesn’t have to be assigned to that doctor. Call your TennCare Representative. They will get the child on “global”. Then either you or the TennCare Representative can get the name of an available doctor in Oak Ridge. Use the new doctor as the PCP, going to him for all primary care while the child resides in that area.

Other MCOs who will assist with “global” PCP assignment:

- Xantus
- THP

Call the TennCare Representative for help with this.

**Q: The foster mother took a child to the doctor to look at a wrist fracture that had healed. The child had the injury before she came into custody. The doctor told her he felt a corrective surgery was required, but he didn't think TennCare would pay for it, so nothing happened.**

A: Call your regional Health Advocacy Unit nurse. Under EPSDT, TennCare covers for all medically necessary services. The doctor needs to make a referral and if it is denied, or there is a problem finding an orthopedist, an appeal needs to be filed. The Health Advocacy nurse can help you with this issue.

**Q: The foster parent took the child to the doctor and got a prescription, but when they went to get it filled, it was not on the TennCare formulary. I need to get the foster parent paid. What do I do?**

A: The foster parent can be paid by using the non-TennCare eligible claim form. A copy of the receipt and this form are needed. See your TennCare Representative. Next time, here's what they need to do.

If the pharmacy says the drug is not on the formulary, ask the pharmacy to call the doctor to see if a generic or substitute is appropriate. If it is, the pharmacy can fill the new/changed prescription. If not, the doctor needs to request prior approval for the drug to be covered by the MCO as medically necessary under EPSDT. (This needs to happen before the prescription is filled for next time.)

If the pharmacy can't get the prescription changed or covered by prior approval, the foster parent needs to request a 72-hour supply of medication until this is worked out. If the pharmacy does not comply with the 72-hour rule, notify your TennCare Representative. They will file an appeal.

**Q: There is not a pharmacy in our area that takes Access Med Plus. What do I do?**

A: Call the TennCare Representative. They will call Access Med Plus and request the name of a pharmacy in the area that takes TennCare. If they don't get one, they will file an appeal.

**Q: The home health agency is reducing the number of hours for the child. What do I do?**

A: Did the doctor change the order or did the MCO just reduce? Contact the TennCare Representative or the Health Advocacy nurse. An appeal for reduced hours should be filed if the MCO reduced hours.

**Q: I have a child who is medically complicated and needs home health supplies. Are these covered?**

A: All home supplies are covered as medically necessary. Get a prescription and call the MCO to find a durable medical supplier. Contact your TennCare Representative if the supplies are denied by the MCO.

**Access to Behavioral Services:**

**Q: I called the CMHC to get a counseling appointment. It is 4 weeks off.**

A: Call the BHO at 1-800-325-7864 (Premier) or 1-800-447-7242 (TBH) and tell them the appointment you can get is that far off. Tell them the child is in custody and you need an appointment within 14 days. If they do not resolve this, contact your TennCare Representative and they will file an appeal.

You may wish to use a private provider. Ask the TennCare Representative for the names of private providers who deliver TennCare counseling services in your area (they can give the information out by zip code). The BHO also has data on providers regarding their specialization and services offered. You may wish to get several names, as the BHO lists are not always current. If you were given a four-week wait by the CMHC and the BHO did not resolve this, you should still file an appeal even if you elect to use a private provider.

**Q: The judge ordered a psychological on a child I have during a permanency hearing. The CMHC says they don't do these.**

A: Psychologicals for TennCare children are covered as medically necessary.

1. Call the BHO to find out where to take the child within 14 days.
2. The provider can get one hour of testing in addition to the intake. That won't be enough. You will need to file a Psychological Evaluation Request Form (5/99 version) with the BHO. Your Health Unit psychologist may have this form or you can obtain it directly from the BHO by calling either of the numbers shown above (both BHOs use the same form). The form can be faxed to the BHO. You may need assistance filling out this form. If so, contact the Health Unit psychologist, he or she will assist you. The BHOs will approve no more than three hours, but these three hours combined with the one hour intake and one hour of testing that is automatically approved will give you a total of five hours.
3. If the testing is denied by the BHO, call the TennCare Representative so they may file an appeal OR call the Health Advocacy psychologists.

For information on psychologicals ask your Health Advocacy psychologist or TennCare Representative for a copy of the booklet call "Obtaining and Using

Psychological Evaluations, June 1999” and/or ask your psychologist to do some training at a “brown bag”.

### **3. More on Appeals/Clarification of Roles**

**From:** Mary Beth Franklyn  
**Subject:** Psychologicals

The TennCare Consumer Advocacy is a contract agency who monitors TennCare services received by custody children. Copies of the Notices that we provide at staffing, and copies of the permanency plans are sent to them following staffings. In addition, they will be receiving monthly treatment notes and type A incident reports from continuum providers. They have the authority to file a TennCare Appeal with the TennCare Solutions Team regarding TennCare services provided by DCS. In addition, they may file a TennCare Appeal on an MCO or BHO service for a custody child, but since DCS has agreed to file these on notice by the MCO or BHO on any adverse action, we have asked that the TennCare Consumer Advocacy send a copy to the CDS TennCare Rep whenever they do file a TennCare MCO or BHO appeal.

Once an Appeal is filed by the TennCare Consumer Advocacy or someone representing the child, it is filed with the TennCare Solutions Team.

This TennCare Solutions Team handles of course MCO and BHO appeals, but also handles the TennCare DCS Appeals that are regarding DCS administered Title XIX (TennCare) services. The TennCare Solutions Team is at the Bureau of TennCare and it is their job to resolve Appeals or issue directives on services.

It is up to the TennCare Solutions Team to handle/resolve the Appeal once it is filed.

Recently, in one of our regions, staff required an inquiry from the TennCare Consumer Advocacy Group AFTER an appeal was filed. DCS responded to the TennCare Consumer Advocacy, and in doing so, then failed to respond to the TennCare Solutions Team. This could have potentially caused DCS to miss important deadlines required under Grier for responding to the TennCare Solutions Team.

So, simply put the roles are as follows:

TennCare Consumer Advocacy files the appeal.

The appeal is received at the Bureau of TennCare by the TennCare Solutions Team and is handled by them. Our responses regarding the appeal go to the TennCare Solutions Team; not to TennCare Consumer Advocacy. TennCare Consumer Advocacy will receive a response, just like any other enrollee, regarding the outcome of the appeal, after the TennCare Solutions Team resolves or orders a directive on the Appeal.

Remember that DCS will also get a copy of this response and if the appeal is not resolved to the child’s favor the Health Unit will notify the Tennessee Association of Legal Services to represent the child.

If you get a call about an Appeal from the TennCare Consumer Advocacy, you can tell them that since an Appeal has been filed, you will direct all responses regarding the Appeal to the

TennCare Solutions Team. They have basically done their job when the Appeal is filed, and the TennCare Solutions Team is to take it from there.

#### **4. Some Definitions**

##### ***A. Consent Decree***

I think while case managers do not need to know the entire background of Consent Decrees, they do need to know that we are implementing this to comply with court order, and their compliance is critical to the department compliance with the court decree.

##### ***B. Arbitrary Denials***

As we discussed in the training the other day, if a foster parent or GAL or someone else speaking for the child requests a particular level of care for the child via phone or conversation, a staffing should be set to discuss the matter. It is not appropriate and will in fact violate the DCS appeals process to dismiss such a request out of hand and not deal with it.

This is important on 2 levels: 1) We must deal with the request and; 2) for all denials, there must be a notice. If we dismiss with no notice, we violate the Consent Decree.

**Example:** A foster parent has a child that is acting out, and asks for the case manager to see about getting the child into Level 2; the case manager must set a staffing, invite the appropriate parties, and if Level 2 is NOT decided upon, provide a notice at the staffing. While it is determined that the child would stay at Level 1, we rejected the Level 2 and that is a denial. A notice is required.

##### ***C. Applies to all children:***

JJ and D & N/exception are children in YDCs. The DCS appeals process applies to all children we serve, whether juvenile justice of Dependent and Neglected. Copies of all Notices of Action go to TennCare Consumer Advocacy, whether the child is JJ or D & N.

The DCS appeals process does not apply to children in the YDCs. For instance, if someone requests a child go to Wilder, they do not need a Notice of Action regarding that staffing decision/outcome.

However, please note: just because the service decided upon was a Level 1 service, it does not mean that there should be a notice given at staffing. Refer back to example above. We think a JJ child should go to a group home; the parent wants the child at a Level 2; then if the decision for group home is made; a Notice of Action is required.

##### ***D. Retaliation***

Appeals should be encouraged and filed on behalf of anyone who has a grievance on services. Case managers shall not retaliate in any way. If a foster parent files an appeal, a case manager must never, in any circumstances imply this will affect

placements or other issues with the department. We need to remind case managers of this. When we train the foster parent advocates, we will remind them in case they get complaints from foster parents about such action by a case manager.

***E. MCO/BHO TennCare Appeals***

A process on MCO/BHO services to ensure TennCare enrollees receive notice of adverse actions and a right to a hearing.

Each MCO and BHO is required to give notice to TennCare enrollees any time they take as “adverse action”; that is, they deny, terminate, reduce, suspend or delay a TennCare service. Since children in custody have TennCare, they get these notices and the right, like all TennCare enrollees, to have appeal rights on all services affected by an adverse action. More simply put, a child needs a psychological evaluation. The provider (probably the local CMHC) makes this request, but the BHO denies the service. The child should get a notice of the denial, and DCS will appeal.

***F. DCS TennCare Appeals***

A process on DCS administered TennCare services to ensure TennCare enrollees receive notice of adverse actions and the right to a hearing. DCS is required to provide notice of any adverse action to the TennCare enrollees in custody to whom DCS provides services. Since determinations about services are provided at a staffing, DCS must give a Notice of Action at staffing, or mail it if individuals do not come.

**EXAMPLE:** A child is in Level 2 care. A foster parent visits the child and reports to the case manager that the child is disrupting and needs are not being met. The foster parent recommends Level 3 be looked at for the child. A staffing must be held; a Notice of Action must be provided at the staffing.

Both MCO/BHO appeals and DCS appeals go to the TennCare Solutions Unit. Appeals are resolved to the benefit of the enrollee or set for hearing, and a hearing must be held in 90 days from the date the appeal was filed.

## APPENDIX C

### 1. Forms:

CS-0072	Youth Grievance Report
CS-0559	Authorization for Release of Child-Specific Information from the Department of Children's Services and Contract Service Providers

### 2. Incident Reporting Manual

Need Forms:

CS-0495A	Monthly Summary of Type A Incidents
CS-0495B	Monthly Summary of Type B Incidents
CS-0496	Serious Incident Report

## **APPENDIX D**

### **Appeals Procedure for Contract Placements**

*as recommended by State Resource Managers and TACC Appeals Committee*

**11/30/99 - 12/1/99**

The state Resource Managers and TACC Appeals Committee members met on 11/30/99 and 12/1/99 to discuss a statewide appeals process. The following were present at the meetings: Sharon Putnam, SE; Fran Priest, TACC; Tom Edwards, TACC; Diane Bremseth, TACC; Randal Lea, TACC; Karen Smith, SWCSA; Kim McGehee, NWCSA; Marcus Hill, Knox CSA; Amy Sexton, UCCSA; Randi Moser, TACC; Tara Sallee, MCCSA; Frank Mix, MCCSA; Sandra Williams, Davidson DCS; Patricia Mitchell, SCCSA; Scott Ridgeway, TCCY; Eileen Thompson, HC; Mitchell Holmes, Shelby; Mary Garrison, TACC; Marla Hale, UC; Pam Hodge, ETCSA.

All in attendance agreed on the following procedures with the exception of Shelby County RM. Shelby County felt a grand region appeals committee would not be beneficial to them. Northeast TN was not represented.

#### **Procedures:**

- ◆ Appeals committee would be responsible for referral packet appeals, disruption appeals for Juvenile Justice children who are not covered under the TennCare appeals procedures, and any other appeals that may not be covered under TennCare appeals procedures.
- ◆ Appeals committee will consist of representatives from the Grand Region to include DCS, CSA, Resource Management, TACC, and TCCY.

#### **Members of Grand Region Appeals Committee:**

- ◆ Members will include 1 DCS representative, 1 CSA representative, 1 Resource Manager representative, 1 TCCY representative, and 2 TACC representatives.
- ◆ The DCS, CSA, and Resource Management representatives will represent each of the three regions within the Grand Region. For example, region #1 will appoint a DCS representative with an alternate DCS representative; region #2 will appoint a CSA representative with an alternate CSA representative; and region #3 will appoint a Resource Management representative with an alternate Resource Management representative. Each DCS, CSA, Resource Management representatives and alternates will be appointed by the Regional Administrators.
- ◆ There will be 1 TCCY representative on each committee with an alternate TCCY representative. Each Grand Region should have two TCCY staff already representing the regions.
- ◆ The 2 TACC representatives on each committee will be nominated by the Regional TACC Associations.

#### **Terms of Service:**

- ◆ Each member is appointed or nominated for a 2-year term with the option of unlimited reappointments.
- ◆ Each committee will be responsible for training new members as noted above.

#### **Chairperson of Appeals Committee:**

- ◆ The members appointed or nominated to the Appeals Committee will elect a chairperson.
- ◆ The chairperson may serve the same terms as each member as noted above.

#### **Voting Members:**

- ◆ There will be one voting member to represent each of the 6 positions.
- ◆ If a member cannot be present to vote, he/she will be responsible to notify his/her alternate to vote.

- ◆ The representative from the region where the child is from for whom the appeal is being made, may not vote on the appeal.
- ◆ If the TACC representative is from the agency making the appeal, he/she may not vote.

**Quorum and Meetings for Appeals Committee:**

- ◆ There must be a quorum of at least 3 members attending the appeals meeting.
- ◆ Each of the voting member representatives will have a vote whether present or not.
- ◆ Each Grand Region Appeals Committee will decide feasible ways to meet, (i.e. conference call), but the expectation is a weekly sit down meeting where all members are present.
- ◆ The location of each meeting will rotate within the Grand Region. The Appeals Committee will decide the location schedule.
- ◆ Each Committee will schedule one day a week and time for the weekly appeals meetings. The Committee will also decide on a deadline day and time for appeals to be received in order to be reviewed at the next meeting. There will not be a meeting if no appeals are received.

**Paperwork needed to make an appeal:**

- ◆ Cover form (MCCSA will provide this form)
- ◆ Letter from agency stating reason for appeal with citation from the Provider Policy Manual
- ◆ Copy of referral packet the received by the provider for the referral (this is only for referral appeals)
- ◆ For disruption appeals, IPP, any supporting documentation for disruption according to Provider Policy Manual, incident reports, progress notes, etc.

**Appeals Committee process and routing:**

- ◆ The provider will send the appeal to the chairperson within 5 working days of receiving the referral packet.
- ◆ The chairperson distributes the information received to the voting members. If a member cannot attend, he/she will forward the information to his/her alternate.
- ◆ The Appeals Committee will meet within 5 working days of receiving the appeal. The Appeal Committee will make a decision on the appeal based on the information received from the provider and according to the Provider Policy Manual.
- ◆ The chairperson will notify DCS, provider, and resource manager by phone following the decision.
- ◆ The chairperson will follow up with a letter regarding the appeal decision within 24 hours to DCS, provider, and resource manager.

**Statistical Data:**

- ◆ The chairperson of each committee will be responsible to maintain statistical data for appeals that have been sent to the committee. (Tom Edwards will be developing a form.)

**Recommendation time to start Grand Region Appeals Committees:**

- ◆ Due to the current inconsistencies of appeals committees across the state, this committee of Resource Managers and TACC recommends this procedure begin January 1, 2000.
- ◆ This committee also would like to share these recommendations with the Regional Administrators in order to get their support.

## APPENDIX E

1. [Administrative Policies and Procedures: 4.22](#)  
*“Job Requirements”*
2. [Administrative Policies and Procedures: 31.2](#)  
*“Program Operations Responsibilities Regarding Runaways and Escapees”*  
Includes Forms:

CS-0296 (Rev. 11/96)	Notice of Apprehension
BI-0083	TBI Missing Child Report
3. [Administrative Policies and Procedures: 16.1](#)  
*“Placement of Delinquent Youth in Family Foster Homes”*
4. [Administrative Policies and Procedures: 16.4](#)  
*“Foster Home Study, Evaluation and Training Process”*  
Includes Forms:

CS-0271	Foster Parent Approval Letter
CS-0377	Release of Information
CS-0411 Rev. 01/00	Foster/Adoption Application for Parenting
CS-0426	Foster or Adoptive Parent/Applicant Medical Report
CS-0431 Rev. 1/00	Monthly Family Income and Expenditures
CS-0539	Release Authorization for Background Investigation
CS-0547	Sex Offender Registry Verification
CS-0553	Discipline Policy
5. [Administrative Policies and Procedures: 16.8](#)  
*“Responsibilities of Approved Department of Children’s Services Foster Parents”*
6. [Administrative Policies and Procedures: 16.10 - BA](#)  
*“Foster Home Capacity”*
7. [Administrative Policies and Procedures: 16.29](#)  
*“Foster Care Board Rates”*
8. [Administrative Policies and Procedures: 16.31 - BA](#)  
*“Permanency Planning for Children/Youth in Department of Children’s Services Foster Care”*
9. [Administrative Policies and Procedures: 16.38](#)  
*“Supervision of Dependent and Neglected and Unruly Children in Custody/Guardianship”*
10. [Administrative Policies and Procedures: 16.43 - BA](#)  
*“Sibling Visitation”*

11. [Administrative Policies and Procedures: 16.45 - BA](#)  
*"Group Care for Children Under Age Six (6)"*
12. [Administrative Policies and Procedures: 16.46 - BA](#)  
*"Assessment and Placement of Children in Foster Care"*
13. [Administrative Policies and Procedures: 16.47 - BA](#)  
*"Placement of Children in Residential Treatment Centers or Other Group Care"*
14. [Administrative Policies and Procedures: 16.48- BA](#)  
*"Conducting Diligent Searches"*  
Includes Form:  
CS-0584 Diligent Search Checklist/Sample Diligent Search Letter
15. [Administrative Policies and Procedures: 16.49 - BA](#)  
*"Dependent/Neglect and Unruly Youth Placement in Detention"*
16. [Administrative Policies and Procedures: 18.31](#)  
*"Religious Programs and Services for Youth in DCS Residential Treatment Facilities"*
17. [Administrative Policies and Procedures: 19.1](#)  
*"Suicide/Self Harm Intervention"*
18. [Administrative Policies and Procedures: 20.24](#)  
*"Informed Consent"*  
Forms Needed:  
CS-0206 Informed Consent to Routine Health Care Services for Minors  
CS-0088 Informed Consent to Non-Routine Medical Care/ Treatment for Minors  
CS-0108 Consent Treatment – Psychotropic Medication  
CS-0545 Informed Consent – Psychotropic Medications or Surgical Procedures
19. [Administrative Policies and Procedures: 20.29](#)  
*"Death of Child/Youth or Department of Children's Services Employee"*  
Forms Needed:  
CS-0166 Accident/Injury/Traumatic Injury Report
20. [Administrative Policies and Procedures: 24.10](#)  
*"Title VI"*

## APPENDIX F

### 1. [Brian A. Settlement Agreement](#)

### 2. **Principles of Practice**

Tennessee Department of Children's Services

- ◆ All children get to grow up in a safe family.
- ◆ Reasonable efforts.
- ◆ Relationships with family and kin always come first.
- ◆ Fast as possible from temporary to permanent.
- ◆ Contractor or not, DCS is responsible for care and protection.
- ◆ Full and equal access to the best available services.
- ◆ Least restrictive, most family-like settings.
- ◆ Stable placements addressing circumstances of removal and trauma of custody.
- ◆ Time is of the essence where one's childhood is concerned.
- ◆ The next best thing to staying at home is staying closest to home.
- ◆ It's not just the child, it's the family's decision in this.
- ◆ Fair hearings, legal rights to all.
- ◆ If it's not documented, it didn't happen.

### 3. [Glossary](#)